

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: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 2:42 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/24/2017 Time: 2:42 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 PRESENCE COVENANT MEDICAL CENTER (14-0113) 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	136,452	22,783	-20,305	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	20,626	-46		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	157,078	22,737	-20,305	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: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 1:24 pm				
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 1400 WEST PARK STREET			PO Box:				1.00					
2.00	City: URBANA			State: IL		Zip Code: 61801		County: CHAMPAIGN			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			PRESENCE COVENANT MEDICAL CENTER		140113	16580	1	07/01/1966	0	P	0	3.00
4.00	Subprovider - IPF												4.00
5.00	Subprovider - IRF			COVENANT REHABILITATION UNIT		14T113	16580	5	10/01/1983	0	P	0	5.00
6.00	Subprovider - (Other)												6.00
7.00	Swing Beds - SNF												7.00
8.00	Swing Beds - NF												8.00
9.00	Hospital-Based SNF												9.00
10.00	Hospital-Based NF												10.00
11.00	Hospital-Based OLTC												11.00
12.00	Hospital-Based HHA												12.00
13.00	Separately Certified ASC												13.00
14.00	Hospital-Based Hospice												14.00
15.00	Hospital-Based Health Clinic - RHC												15.00
16.00	Hospital-Based Health Clinic - FQHC												16.00
17.00	Hospital-Based (CMHC) I												17.00
18.00	Renal Dialysis												18.00
19.00	Other												19.00
									From:	To:			
									1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)								01/01/2016	12/31/2016	20.00		
21.00	Type of Control (see instructions)								1		21.00		
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.								Y	N	22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)								Y	Y	22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.								N	N	22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								N	N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								2	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.				2,920	1,578	0	0	347	988	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.				207	235	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 1:24 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	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
				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	N	0
				1.00	2.00	3.00
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.			Y	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				109.00	
1.00							
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
1.00 2.00 3.00							
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				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:	0		0		2,649,358	
1.00 2.00							
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.06		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: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 1:24 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	14H082	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: PRESENCE HEALTH NETWORK	Contractor's Name: NGS		Contractor's Number: 0131		141.00	
142.00	Street: 200 S WACKER DRIVE	PO Box:				142.00	
143.00	City: CHI CAGO	State: IL	Zip Code: 60606	143.00			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00		
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	08/26/2016	146.00			
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			Y	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	149.00		
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0	168.00		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25	169.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 1:24 pm
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 1:24 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	R	05/31/2016		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y				5.00	
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	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.				Y	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	04/30/2016	Y	04/30/2016	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: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 1:24 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNE		LITTLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3721		ANNE.LITTLE@PRESENCEHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 1:24 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.	DIRECTOR, REIMB		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: 14-0113

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 1:24 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	156	56,940	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)		156	56,940	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	13	4,745	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)		169	61,685	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125		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)		194				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)		6	2,190			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: 14-0113

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 1:24 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)	7,160	1,595	19,837			1.00
2.00 HMO and other (see instructions)	3,387	3,768				2.00
3.00 HMO IPF Subprovider	0	276				3.00
4.00 HMO IRF Subprovider	479	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)	7,160	1,595	19,837			7.00
8.00 INTENSIVE CARE UNIT	1,548	62	3,358			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		408	1,612			13.00
14.00 Total (see instructions)	8,708	2,065	24,807	9.03	601.14	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	2,657	166	4,415	0.00	19.85	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	105			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)				9.03	620.99	27.00
28.00 Observation Bed Days		493	3,871			28.00
29.00 Ambulance Trips	2,950					29.00
30.00 Employee discount days (see instruction)			149			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	1	259	704			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			56			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0113

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 1:24 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,227	646	6,587	1.00
2.00 HMO and other (see instructions)			873	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,227	646	6,587	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	228	0	368	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: 14-0113

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2017 1:24 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	37,624,971	0	37,624,971	1,296,635.46	29.02
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		762,829	0	762,829	20,671.20	36.90
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)		4,556,383	0	4,556,383	185,667.31	24.54
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		5,100,609	0	5,100,609	141,278.34	36.10
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		181,102	0	181,102	1,201.65	150.71
14.00	Home office and/or related organization salaries and wage-related costs		9,995,444	0	9,995,444	191,574.00	52.18
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		24,000	0	24,000	240.00	100.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,983,424	0	7,983,424		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,303,713	0	1,303,713		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-163,841	163,841	0	0.00	0.00
27.00	Administrative & General	5.00	3,637,553	-163,841	3,473,712	110,533.74	31.43

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0113

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2017 1:24 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	848,066	0	848,066	30,761.72	30.00
31.00	Laundry & Linen Service	8.00	130,549	0	130,549	6,396.50	31.00
32.00	Housekeeping	9.00	886,663	0	886,663	59,497.18	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	550,867	-419,846	131,021	9,839.99	34.00
35.00	Dietary under contract (see instructions)		481,829	0	481,829	10,400.00	35.00
36.00	Cafeteria	11.00	0	419,846	419,846	31,531.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	1,345,574	0	1,345,574	43,113.65	38.00
39.00	Central Services and Supply	14.00	36,546	0	36,546	1,462.70	39.00
40.00	Pharmacy	15.00	1,505,194	0	1,505,194	32,947.80	40.00
41.00	Medical Records & Medical Records Library	16.00	177,929	0	177,929	12,401.22	41.00
42.00	Social Service	17.00	690,210	0	690,210	17,399.44	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0113

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2017 1:24 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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	37,343,971	0	37,343,971	1,286,364.26	29.03	1.00
2.00	Excluded area salaries (see instructions)	4,556,383	0	4,556,383	185,667.31	24.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,787,588	0	32,787,588	1,100,696.95	29.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	15,277,155	0	15,277,155	334,053.99	45.73	4.00
5.00	Subtotal wage-related costs (see inst.)	7,983,424	0	7,983,424	0.00	24.35	5.00
6.00	Total (sum of lines 3 thru 5)	56,048,167	0	56,048,167	1,434,750.94	39.06	6.00
7.00	Total overhead cost (see instructions)	10,127,139	0	10,127,139	366,285.58	27.65	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2017 1:24 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,510,219	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		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)		3,963,265	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		79,153	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		28,141	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		130,649	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		566,469	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		2,637,058	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		122,951	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))		158,990	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		90,242	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9,287,137	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/24/2017 1:24 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		5,100,609	9,287,137
2.00	Hospital		5,100,609	9,287,137
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: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/24/2017 1:24 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.176242	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			10,163,672	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			84,456,886	6.00
7.00	Medicaid cost (line 1 times line 6)			14,884,851	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)			4,721,179	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)			4,721,179	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	10,786,652	1,969,846	12,756,498	
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,901,061	347,170	2,248,231	
22.00	Partial payment by patients approved for charity care	56,791	149,382	206,173	
23.00	Cost of charity care (line 21 minus line 22)	1,844,270	197,788	2,042,058	
				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)			4,628,341	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			286,759	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			4,341,582	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			765,169	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,807,227	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,528,406	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0113		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		1,865,829	1,865,829	548,540	2,414,369	1.00
2.00	00200		0	0	5,729,527	5,729,527	2.00
3.00	00300		171,086	171,086	-171,086	0	3.00
4.00	00400	-163,841	279,145	115,304	163,841	279,145	4.00
5.01	00540	256,239	475,752	731,991	-9,532	722,459	5.01
5.02	00550	0	176,592	176,592	-176,592	0	5.02
5.03	00560	0	628,463	628,463	-628,463	0	5.03
5.04	00570	548,128	206,564	754,692	-3,442	751,250	5.04
5.05	00580	0	232	232	0	232	5.05
5.06	00590	2,833,186	27,042,350	29,875,536	734,329	30,609,865	5.06
6.00	00600	0	0	0	0	0	6.00
7.00	00700	848,066	5,836,552	6,684,618	-1,632,971	5,051,647	7.00
8.00	00800	130,549	502,098	632,647	-219	632,428	8.00
9.00	00900	886,663	664,553	1,551,216	-4,068	1,547,148	9.00
10.00	01000	550,867	1,191,201	1,742,068	-1,332,578	409,490	10.00
11.00	01100	0	0	0	1,327,727	1,327,727	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,345,574	600,182	1,945,756	-144,414	1,801,342	13.00
14.00	01400	36,546	577,028	613,574	-611,948	1,626	14.00
15.00	01500	1,505,194	3,575,711	5,080,905	-3,103,791	1,977,114	15.00
16.00	01600	177,929	715,685	893,614	-258	893,356	16.00
17.00	01700	690,210	197,377	887,587	0	887,587	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	762,829	762,829	21.00
22.00	02200	0	1,539,184	1,539,184	-652,511	886,673	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,963,835	2,813,571	11,777,406	-1,358,070	10,419,336	30.00
31.00	03100	2,097,089	1,059,570	3,156,659	-38,355	3,118,304	31.00
41.00	04100	1,283,595	2,038,079	3,321,674	-899,837	2,421,837	41.00
43.00	04300	359,272	658,684	1,017,956	-2,724	1,015,232	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,485,178	12,358,559	15,843,737	-6,596,884	9,246,853	50.00
50.01	03330	787,235	732,797	1,520,032	-220,708	1,299,324	50.01
51.00	05100	549,407	143,544	692,951	-30,525	662,426	51.00
52.00	05200	0	180,866	180,866	1,145,130	1,325,996	52.00
53.00	05300	31,003	2,373,190	2,404,193	-105,111	2,299,082	53.00
54.00	05400	943,621	356,158	1,299,779	-290,825	1,008,954	54.00
54.01	03630	228,527	81,060	309,587	57,680	367,267	54.01
54.02	03440	48,567	43,885	92,452	-17,775	74,677	54.02
55.00	05500	0	0	0	0	0	55.00
55.01	03480	0	0	0	0	0	55.01
56.00	05600	99,312	234,501	333,813	30,375	364,188	56.00
57.00	05700	336,486	217,440	553,926	52,703	606,629	57.00
58.00	05800	123,819	115,049	238,868	-18,354	220,514	58.00
59.00	05900	1,169,307	5,656,458	6,825,765	-2,874,701	3,951,064	59.00
60.00	06000	0	4,934,029	4,934,029	-93,294	4,840,735	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	467,211	467,211	0	467,211	63.00
65.00	06500	984,838	468,219	1,453,057	-135,225	1,317,832	65.00
66.00	06600	0	516,683	516,683	334,142	850,825	66.00
67.00	06700	0	404,456	404,456	367,622	772,078	67.00
68.00	06800	0	46,715	46,715	187,032	233,747	68.00
69.01	03140	413,263	264,238	677,501	-28,901	648,600	69.01
71.00	07100	0	0	0	4,162,660	4,162,660	71.00
72.00	07200	0	0	0	5,482,036	5,482,036	72.00
73.00	07300	0	0	0	3,095,882	3,095,882	73.00
74.00	07400	143,900	319,986	463,886	-213	463,673	74.00
76.97	07697	357,349	96,073	453,422	-6,865	446,557	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	2,301,270	1,464,185	3,765,455	-167,815	3,597,640	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,992,985	2,068,865	4,061,850	-48,462	4,013,388	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		2,065,497	2,065,497	-2,065,497	0	113.00
118.00		36,345,168	88,425,152	124,770,320	710,041	125,480,361	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet A Date/Time Prepared: 5/24/2017 1:24 pm		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,758	144,657	194,415	-1,646	192,769	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	932,333	1,501,015	2,433,348	-5,690	2,427,658	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	187,549	584,056	771,605	-2,845	768,760	192.01
192.02	19202	REAL ESTATE	0	188,954	188,954	-679,487	-490,533	192.02
192.03	19203	FOUNDATION	1,111	111,301	112,412	-19,793	92,619	192.03
192.04	19204	OUTREACH PROGRAMS	61,245	28,464	89,709	-580	89,129	192.04
192.05	19205	UNASSIGNED	47,807	156,005	203,812	0	203,812	192.05
200.00		TOTAL (SUM OF LINES 118-199)	37,624,971	91,139,604	128,764,575	0	128,764,575	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0113

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

Worksheet A
Date/Time Prepared:
5/24/2017 1:24 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	311,740	2,726,109	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-239,864	5,489,663	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	438,642	717,787	4.00
5.01	00540	NONPATIENT TELEPHONE	-47,607	674,852	5.01
5.02	00550	DATA PROCESSING	0	0	5.02
5.03	00560	PURCH, RCVI NG, STORI NG	0	0	5.03
5.04	00570	ADM I TTI NG	0	751,250	5.04
5.05	00580	CASHI ERI NG, A/R	52,355	52,587	5.05
5.06	00590	OTHER ADMIN & GEN	-6,793,099	23,816,766	5.06
6.00	00600	MAI NTENANCE & REPAI RS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	5,051,647	7.00
8.00	00800	LAUNDRY & LI NEN SERVICE	36,561	668,989	8.00
9.00	00900	HOUSEKEEPING	-690	1,546,458	9.00
10.00	01000	DI ETARY	-22	409,468	10.00
11.00	01100	CAFETERIA	-318,486	1,009,241	11.00
12.00	01200	MAI NTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSI NG ADM I NI STRATI ON	-160	1,801,182	13.00
14.00	01400	CENTRAL SERVI CES & SUPPLY	406,006	407,632	14.00
15.00	01500	PHARMACY	-8,106	1,969,008	15.00
16.00	01600	MEDI CAL RECORDS & LI BRARY	694,772	1,588,128	16.00
17.00	01700	SOCI AL SERVI CE	-11,319	876,268	17.00
19.00	01900	NONPHYSI CI AN ANESTHETI STS	0	0	19.00
20.00	02000	NURSI NG SCHOOL	0	0	20.00
21.00	02100	I & R SERVI CES-SALARY & FR I NGES APPRV	0	762,829	21.00
22.00	02200	I & R SERVI CES-OTHER PRGM COSTS APPRV	0	886,673	22.00
23.00	02300	PARAMED ED PRGM-(SPECI FY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-23,100	10,396,236	30.00
31.00	03100	I NTENSI VE CARE UNI T	-89,488	3,028,816	31.00
41.00	04100	SUBPROVI DER - I RF	-56,000	2,365,837	41.00
43.00	04300	NURSERY	-550,000	465,232	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATI NG ROOM	1,345	9,248,198	50.00
50.01	03330	ENDOSCOPY	0	1,299,324	50.01
51.00	05100	RECOVERY ROOM	0	662,426	51.00
52.00	05200	DELI VERY ROOM & LABOR ROOM	-90	1,325,906	52.00
53.00	05300	ANESTHESI OLOGY	0	2,299,082	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	1,008,954	54.00
54.01	03630	ULTRASOUND	-90	367,177	54.01
54.02	03440	MAMMOGRAPHY	0	74,677	54.02
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	55.00
55.01	03480	ONCOLOGY	0	0	55.01
56.00	05600	RADI OI SOTOPE	0	364,188	56.00
57.00	05700	CT SCAN	-495	606,134	57.00
58.00	05800	MRI	0	220,514	58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	-1,321	3,949,743	59.00
60.00	06000	LABORATORY	-62,155	4,778,580	60.00
62.30	06250	BLOOD CLOTTI NG FOR HEMOPHI LI ACS	0	0	62.30
63.00	06300	BLOOD STORI NG, PROCESSI NG & TRANS.	0	467,211	63.00
65.00	06500	RESPI RATORY THERAPY	-2,833	1,314,999	65.00
66.00	06600	PHYSI CAL THERAPY	0	850,825	66.00
67.00	06700	OCCUPATI ONAL THERAPY	0	772,078	67.00
68.00	06800	SPEECH PATHOLOGY	0	233,747	68.00
69.01	03140	CARDI OLOGY	-78,007	570,593	69.01
71.00	07100	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	4,162,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATI ENTS	0	5,482,036	72.00
73.00	07300	DRUGS CHARGED TO PATI ENTS	0	3,095,882	73.00
74.00	07400	RENAL DI ALYSI S	0	463,673	74.00
76.97	07697	CARDI AC REHABI LI TATI ON	-4,472	442,085	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-532,052	3,065,588	91.00
92.00	09200	OBSERVATI ON BEDS (NON-DI STI NCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVI CES	-20,319	3,993,069	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	I NTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LI NES 1-117)	-6,898,354	118,582,007	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	192,769	190.00
192.00	19200	PHYSI CI ANS' PRI VATE OFFI CES	0	2,427,658	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0113

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

Worksheet A
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.01	19201	COVENANT OUTPATIENT PHARMACY	0	768,760	192.01
192.02	19202	REAL ESTATE	0	-490,533	192.02
192.03	19203	FOUNDATION	0	92,619	192.03
192.04	19204	OUTREACH PROGRAMS	0	89,129	192.04
192.05	19205	UNASSIGNED	0	203,812	192.05
200.00		TOTAL (SUM OF LINES 118-199)	-6,898,354	121,866,221	200.00

RECLASSIFICATIONS

Provider CCN: 14-0113

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

Worksheet A-6
Date/Time Prepared:
5/24/2017 1:24 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,095,882	1.00	
	TOTALS		0	3,095,882		
B - REHAB SERVICES						
1.00	PHYSICAL THERAPY	66.00	0	336,064	1.00	
2.00	OCCUPATIONAL THERAPY	67.00	0	367,622	2.00	
3.00	SPEECH PATHOLOGY	68.00	0	187,032	3.00	
	TOTALS		0	890,718		
C - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	604,095	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,461,402	2.00	
	TOTALS		0	2,065,497		
D - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,728,288	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,865,830	2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,313,196	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
37.00		0.00	0	0	37.00	
38.00		0.00	0	0	38.00	
39.00		0.00	0	0	39.00	
40.00		0.00	0	0	40.00	
41.00		0.00	0	0	41.00	
42.00		0.00	0	0	42.00	
43.00		0.00	0	0	43.00	
44.00		0.00	0	0	44.00	
	TOTALS		0	5,907,314		
E - OTHER RECLASSIFICATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	163,841	0	1.00	
2.00	OTHER ADMIN & GEN	5.06	0	176,592	2.00	
3.00	OTHER ADMIN & GEN	5.06	0	628,463	3.00	
	TOTALS		163,841	805,055		
F - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,162,660	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	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	

RECLASSIFICATIONS

Provider CCN: 14-0113

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

Worksheet A-6

Date/Time Prepared:
5/24/2017 1:24 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	4,162,660	
G - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,039,701	264,867	1.00
	TOTALS		1,039,701	264,867	
I - INTERNS & RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	762,829	1.00
	TOTALS		0	762,829	
J - RADIOLOGY SHARED SERVICES					
1.00	MAMMOGRAPHY	54.02	11,336	2,701	1.00
2.00	MRI	58.00	28,901	6,978	2.00
3.00	RADIOISOTOPE	56.00	23,181	9,752	3.00
4.00	CT SCAN	57.00	78,541	16,183	4.00
5.00	ULTRASOUND	54.01	53,342	9,044	5.00
	TOTALS		195,301	44,658	
M - RECLASSIFICATION OF MOB EXPENSE					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	110,318	1.00
	TOTALS		0	110,318	
N - DIETARY RECLASSIFICATION					
1.00	CAFETERIA	11.00	419,846	907,881	1.00
	TOTALS		419,846	907,881	
P - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,482,036	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
	TOTALS		0	5,482,036	
R - COUNTY PLAZA LEASE					
1.00	OTHER ADMIN & GEN	5.06	0	219,096	1.00
	TOTALS		0	219,096	
500.00	Grand Total: Increases		1,818,689	24,718,811	500.00

RECLASSIFICATIONS

Provider CCN: 14-0113

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

Worksheet A-6
Date/Time Prepared:
5/24/2017 1:24 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - PHARMACY							
1.00	PHARMACY	15.00	0	3,095,882	0		1.00
	TOTALS		0	3,095,882			
B - REHAB SERVICES							
1.00	SUBPROVIDER - IRF	41.00	0	336,064	0		1.00
2.00	SUBPROVIDER - IRF	41.00	0	367,622	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	187,032	0		3.00
	TOTALS		0	890,718			
C - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	604,095	11		1.00
2.00	INTEREST EXPENSE	113.00	0	1,461,402	11		2.00
	TOTALS		0	2,065,497			
D - DEPRECIATION EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,865,830	9		1.00
2.00	NONPATIENT TELEPHONE	5.01	0	9,532	9		2.00
3.00	OTHER ADMIN & GEN	5.06	0	33,818	9		3.00
4.00	OTHER ADMIN & GEN	5.06	0	27,751	9		4.00
5.00	ADMINISTRATION	5.04	0	3,442	9		5.00
6.00	OTHER ADMIN & GEN	5.06	0	64,412	9		6.00
7.00	OPERATION OF PLANT	7.00	0	1,632,971	9		7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	0	219	9		8.00
9.00	HOUSEKEEPING	9.00	0	4,068	9		9.00
10.00	DIETARY	10.00	0	4,851	9		10.00
11.00	NURSING ADMINISTRATION	13.00	0	144,414	9		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	53,036	9		12.00
13.00	PHARMACY	15.00	0	7,909	9		13.00
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	258	9		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	53,502	9		15.00
16.00	INTENSIVE CARE UNIT	31.00	0	38,355	9		16.00
17.00	SUBPROVIDER - IRF	41.00	0	9,119	9		17.00
18.00	NURSERY	43.00	0	2,724	9		18.00
19.00	OPERATING ROOM	50.00	0	499,045	9		19.00
20.00	ENDOSCOPY	50.01	0	14,554	9		20.00
21.00	RECOVERY ROOM	51.00	0	30,525	9		21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	80,429	9		22.00
23.00	ANESTHESIOLOGY	53.00	0	6,190	9		23.00
24.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,284	9		24.00
25.00	ULTRASOUND	54.01	0	4,706	9		25.00
26.00	MAMMOGRAPHY	54.02	0	7,819	9		26.00
27.00	RADIOISOTOPE	56.00	0	2,558	9		27.00
28.00	CT SCAN	57.00	0	42,021	9		28.00
29.00	MRI	58.00	0	54,233	9		29.00
30.00	CARDIAC CATHETERIZATION	59.00	0	535,803	9		30.00
31.00	LABORATORY	60.00	0	93,294	9		31.00
32.00	RESPIRATORY THERAPY	65.00	0	16,331	9		32.00
33.00	PHYSICAL THERAPY	66.00	0	1,922	9		33.00
34.00	CARDIOLOGY	69.01	0	28,901	9		34.00
35.00	RENAL DIALYSIS	74.00	0	213	9		35.00
36.00	CARDIAC REHABILITATION	76.97	0	6,865	9		36.00
37.00	EMERGENCY	91.00	0	54,321	9		37.00
38.00	AMBULANCE SERVICES	95.00	0	48,462	9		38.00
39.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,646	9		39.00
40.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,690	9		40.00
41.00	COVENANT OUTPATIENT PHARMACY	192.01	0	2,845	9		41.00
42.00	REAL ESTATE	192.02	0	350,073	9		42.00
43.00	FOUNDATION	192.03	0	19,793	9		43.00
44.00	OUTREACH PROGRAMS	192.04	0	580	0		44.00
	TOTALS		0	5,907,314			
E - OTHER RECLASSIFICATION							
1.00	OTHER ADMIN & GEN	5.06	163,841	0	0		1.00
2.00	DATA PROCESSING	5.02	0	176,592	0		2.00
3.00	PURCH, RCVING, STORING	5.03	0	628,463	0		3.00
	TOTALS		163,841	805,055			
F - MEDICAL SUPPLIES							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	79,009	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	266,406	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	118,894	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	528,248	0		4.00
5.00	EMERGENCY	91.00	0	113,494	0		5.00
6.00	OPERATING ROOM	50.00	0	1,710	0		6.00
7.00	OPERATING ROOM	50.00	0	2,652,360	0		7.00
9.00	ENDOSCOPY	50.01	0	205,940	0		9.00
10.00	OPERATING ROOM	50.00	0	67,484	0		10.00

RECLASSIFICATIONS

Provider CCN: 14-0113

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

Worksheet A-6

Date/Time Prepared:
5/24/2017 1:24 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
11.00	ANESTHESIOLOGY	53.00	0	97,404	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,718	0	12.00
13.00	MAMMOGRAPHY	54.02	0	23,993	0	13.00
	TOTALS		0	4,162,660		
G - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1,039,701	264,867	0	1.00
	TOTALS		1,039,701	264,867		
I - INTERNS & RESIDENTS						
1.00	I&R SERVICES-OTHER PRGM	22.00	0	762,829	0	1.00
	COSTS APPRV					
	TOTALS		0	762,829		
J - RADIOLOGY SHARED SERVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	11,336	2,701	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	28,901	6,978	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	23,181	9,752	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	78,541	16,183	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	53,342	9,044	0	5.00
	TOTALS		195,301	44,658		
M - RECLASSIFICATION OF MOB EXPENSE						
1.00	REAL ESTATE	192.02	0	110,318	0	1.00
	TOTALS		0	110,318		
N - DIETARY RECLASSIFICATION						
1.00	DIETARY	10.00	419,846	907,881	0	1.00
	TOTALS		419,846	907,881		
P - IMPLANT SUPPLIES						
1.00	CARDIAC CATHETERIZATION	59.00	0	2,072,492	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	30,664	0	2.00
3.00	OPERATING ROOM	50.00	0	3,376,285	0	3.00
4.00	ENDOSCOPY	50.01	0	214	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	864	0	5.00
6.00	ANESTHESIOLOGY	53.00	0	1,517	0	6.00
	TOTALS		0	5,482,036		
R - COUNTY PLAZA LEASE						
1.00	REAL ESTATE	192.02	0	219,096	0	1.00
	TOTALS		0	219,096		
500.00	Grand Total: Decreases		1,818,689	24,718,811		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0113

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2017 1:24 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,601,096	0	0	47,026	1.00
2.00	Land Improvements	4,804,715	165,731	0	0	2.00
3.00	Buildings and Fixtures	63,043,199	67,858	0	3,534,667	3.00
4.00	Building Improvements	1,608,824	1,390,739	0	1,538,626	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	64,932,066	3,862,675	0	109,407	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,989,900	5,487,003	0	5,229,726	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	139,989,900	5,487,003	0	5,229,726	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,554,070	0			1.00
2.00	Land Improvements	4,970,446	0			2.00
3.00	Buildings and Fixtures	59,576,390	0			3.00
4.00	Building Improvements	1,460,937	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	68,685,334	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	140,247,177	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	140,247,177	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0113

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2017 1:24 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	1,865,829	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,865,829	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,865,829				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,865,829				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0113

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	64,546,837	0	64,546,837	0.479214	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	70,146,271	0	70,146,271	0.520786	0	2.00
3.00	Total (sum of lines 1-2)	134,693,108	0	134,693,108	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	81,987	81,987	2,068,803	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	89,099	89,099	4,008,777	0	2.00
3.00	Total (sum of lines 1-2)	0	171,086	171,086	6,077,580	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	575,319	0	0	81,987	2,726,109	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,391,787	0	0	89,099	5,489,663	2.00
3.00	Total (sum of lines 1-2)	1,967,106	0	0	171,086	8,215,772	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0113

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

Worksheet A-8

Date/Time Prepared:
5/24/2017 1:24 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	-28,776	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-69,615	CAP REL COSTS-MVBLE EQUIP		2.00	11 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		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)	A	-47,607	NONPATIENT TELEPHONE		5.01	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-3,228,046				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-875,895				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-318,486	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-2,193	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS		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 CLINICAL EDUCATION MIS INCOME	B	-160	NURSING ADMINISTRATION		13.00	0 33.00
34.00 QUALITY ASSURANCE MIS INCOME	B	-65,000	OTHER ADMIN & GEN		5.06	0 34.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
35.00	CARDIO PULM REHAB FITNESS	B	-4,472	CARDIAC REHABILITATION	76.97	0	35.00
36.00	ENVIRONMENTAL SERVICES MISC INCOME	B	-690	HOUSEKEEPING	9.00	0	36.00
37.00	PHARMACY MISC INCOME	B	-8,106	PHARMACY	15.00	0	37.00
38.00	EMS RESOURCE HOSP MISC INCOME	B	-115,850	EMERGENCY	91.00	0	38.00
39.00	LABOR & DELY MISC INCOME	B	-90	DELIVERY ROOM & LABOR ROOM	52.00	0	39.00
40.00	ADMINISTRATION MISC INCOME	B	-114,955	OTHER ADMIN & GEN	5.06	0	40.00
42.00	ADMINISTRATION MISC INCOME	B	-6,297	OTHER ADMIN & GEN	5.06	0	42.00
43.00	ADMINISTRATION GRANT REVENUE	B	-122,671	OTHER ADMIN & GEN	5.06	0	43.00
44.00	INTEREST INCOME	B	-11,016	OTHER ADMIN & GEN	5.06	0	44.00
45.00	ADMINISTRATION MISC INCOME	B	-1,201,622	OTHER ADMIN & GEN	5.06	0	45.00
46.00	EMPLOYEE HEALTH MISC INCOME	B	-29,963	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46.00
47.00	PATIENT ACCOUNTING INV INC	B	-164,755	CASHIERING, A/R	5.05	0	47.00
48.00	DEFINED BENEFIT PENSIONS	A	-289,874	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
49.02	UR/CARE MANAGEMENT COMMITT TO POOR	A	-11,319	SOCIAL SERVICE	17.00	0	49.02
49.03	AMBULANCE CABLE TV	A	-4,399	AMBULANCE SERVICES	95.00	0	49.03
49.04	CBISA PCMC	A	-16,712	OTHER ADMIN & GEN	5.06	0	49.04
49.05	INCOME TAX	A	-52,424	OTHER ADMIN & GEN	5.06	0	49.05
49.07	DIETARY SALES TAX	A	-22	DIETARY	10.00	0	49.07
49.09	MARKETING AND ADVERTISING	A	-91,282	OTHER ADMIN & GEN	5.06	0	49.09
49.10	MARKETING AND ADVERTISING	A	-137	OTHER ADMIN & GEN	5.06	0	49.10
49.11	AMBULANCE REAL ESTATE TAX	A	-15,920	AMBULANCE SERVICES	95.00	0	49.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,898,354				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: 14-0113

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2017 1:24 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	5.06	OTHER ADMIN & GEN	ADMINISTRATIVE FEE	10,742,063	15,399,101 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	340,516	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	758,479	0 3.00
3.01	5.05	CASHIERING, A/R	PATIENT ACCOUNTS	217,110	0 3.01
3.02	5.06	OTHER ADMIN & GEN	INFORMATION SYSTEMS	1,230,069	0 3.02
3.03	5.06	OTHER ADMIN & GEN	PURCHASING	12,736	0 3.03
3.04	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICE	406,006	0 3.04
3.05	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	36,561	0 3.05
3.06	31.00	INTENSIVE CARE UNIT	EICU	304,666	0 3.06
3.07	2.00	CAP REL COSTS-MVBLE EQUIP	ME DEPRECIATION	-170,249	0 3.07
3.08	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	696,965	0 3.08
3.09	0.00			0	0 3.09
3.10	0.00			0	0 3.10
4.00	60.00	LABORATORY	ALVERNO LABS	4,741,925	4,793,641 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			19,316,847	20,192,742 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. 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	PRESENCE HEALTH	100.00	6.00
7.00	C	0.00	APHL LABS	66.70	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: 14-0113

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2017 1:24 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	-4,657,038	0		1.00
2.00	340,516	9		2.00
3.00	758,479	0		3.00
3.01	217,110	0		3.01
3.02	1,230,069	0		3.02
3.03	12,736	0		3.03
3.04	406,006	0		3.04
3.05	36,561	0		3.05
3.06	304,666	0		3.06
3.07	-170,249	9		3.07
3.08	696,965	11		3.08
3.09	0	0		3.09
3.10	0	0		3.10
4.00	-51,716	0		4.00
5.00	-875,895			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	HEALTH MANAGEMENT		6.00
7.00	LAB SERVICE		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: 14-0113

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2017 1:24 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	5.06	OTHER ADMIN & GEN	1,724,934	1,669,934	55,000	211,500	288	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	23,100	23,100	0	181,300	0	3.00
4.00	69.01	CARDIOLOGY	78,007	78,007	0	211,500	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	8,784	0	8,784	246,400	63	5.00
6.00	91.00	EMERGENCY	416,202	416,202	0	211,500	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	408,796	390,796	18,000	211,500	144	7.00
8.00	60.00	LABORATORY	63,000	0	63,000	260,300	420	8.00
9.00	5.06	OTHER ADMIN & GEN	1,101	1,101	0	211,500	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	23,418	0	23,418	271,900	187	10.00
11.00	57.00	CT SCAN	495	495	0	271,900	0	11.00
12.00	54.01	ULTRASOUND	90	90	0	271,900	0	12.00
13.00	65.00	RESPIRATORY THERAPY	12,900	0	12,900	211,500	99	13.00
14.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	24,000	0	24,000	211,500	240	14.00
15.00	41.00	SUBPROVIDER - IRF	56,000	56,000	0	211,500	0	15.00
16.00	50.00	OPERATING ROOM	-1,345	-1,345	0	246,400	0	16.00
17.00	43.00	NURSERY	550,000	550,000	0	169,700	0	17.00
200.00			3,389,482	3,184,380	205,102		1,441	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	5.06	OTHER ADMIN & GEN	29,285	1,464	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	69.01	CARDIOLOGY	0	0	0	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	7,463	373	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	14,642	732	0	0	0	7.00
8.00	60.00	LABORATORY	52,561	2,628	0	0	0	8.00
9.00	5.06	OTHER ADMIN & GEN	0	0	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	24,445	1,222	0	0	0	10.00
11.00	57.00	CT SCAN	0	0	0	0	0	11.00
12.00	54.01	ULTRASOUND	0	0	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	10,067	503	0	0	0	13.00
14.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	24,404	1,220	0	0	0	14.00
15.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	15.00
16.00	50.00	OPERATING ROOM	0	0	0	0	0	16.00
17.00	43.00	NURSERY	0	0	0	0	0	17.00
200.00			162,867	8,142	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	5.06	OTHER ADMIN & GEN	0	29,285	25,715	1,695,649		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	23,100		3.00
4.00	69.01	CARDIOLOGY	0	0	0	78,007		4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	7,463	1,321	1,321		5.00
6.00	91.00	EMERGENCY	0	0	0	416,202		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	14,642	3,358	394,154		7.00
8.00	60.00	LABORATORY	0	52,561	10,439	10,439		8.00
9.00	5.06	OTHER ADMIN & GEN	0	0	0	1,101		9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	24,445	0	0		10.00
11.00	57.00	CT SCAN	0	0	0	495		11.00
12.00	54.01	ULTRASOUND	0	0	0	90		12.00
13.00	65.00	RESPIRATORY THERAPY	0	10,067	2,833	2,833		13.00
14.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	24,404	0	0		14.00
15.00	41.00	SUBPROVIDER - IRF	0	0	0	56,000		15.00
16.00	50.00	OPERATING ROOM	0	0	0	-1,345		16.00
17.00	43.00	NURSERY	0	0	0	550,000		17.00
200.00			0	162,867	43,666	3,228,046		200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/24/2017 1:24 pm		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,726,109	2,726,109			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,489,663		5,489,663		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	717,787	1,401	0	719,188	4.00
5.01 00540	NONPATIENT TELEPHONE	674,852	5,265	22,621	4,898	707,636
5.02 00550	DATA PROCESSING	0	0	0	0	0
5.03 00560	PURCH, RCVING, STORING	0	0	0	0	0
5.04 00570	ADMINISTRATIVE	751,250	15,506	6,453	10,477	16,988
5.05 00580	CASHIERING, A/R	52,587	2,073	0	0	2,614
5.06 00590	OTHER ADMIN & GEN	23,816,766	154,476	174,185	51,025	147,017
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	5,051,647	575,610	795,126	16,211	14,375
8.00 00800	LAUNDRY & LINEN SERVICE	668,989	7,027	520	2,495	1,307
9.00 00900	HOUSEKEEPING	1,546,458	31,958	9,654	16,949	5,227
10.00 01000	DIETARY	409,468	83,041	1,827	2,504	9,148
11.00 01100	CAFETERIA	1,009,241	18,626	3,759	8,025	19,602
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	1,801,182	3,452	342,722	25,721	4,574
14.00 01400	CENTRAL SERVICES & SUPPLY	407,632	95,441	187,060	699	11,108
15.00 01500	PHARMACY	1,969,008	24,657	15,077	28,772	16,988
16.00 01600	MEDICAL RECORDS & LIBRARY	1,588,128	59,988	612	3,401	20,909
17.00 01700	SOCIAL SERVICE	876,268	4,536	0	13,193	9,801
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	762,829	0	0	0	653
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	886,673	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,396,236	455,389	123,247	151,456	103,891
31.00 03100	INTENSIVE CARE UNIT	3,028,816	73,363	91,024	40,086	12,415
41.00 04100	SUBPROVIDER - I&R	2,365,837	95,557	21,425	24,536	29,403
43.00 04300	NURSERY	465,232	27,697	6,465	6,867	7,841
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,248,198	198,957	1,183,257	66,619	38,551
50.01 03330	ENDOSCOPY	1,299,324	31,850	34,542	15,048	12,415
51.00 05100	RECOVERY ROOM	662,426	17,261	72,442	10,502	14,375
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,325,906	69,557	190,873	19,874	13,068
53.00 05300	ANESTHESIOLOGY	2,299,082	2,918	14,690	593	1,960
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,008,954	61,923	100,348	14,304	16,988
54.01 03630	ULTRASOUND	367,177	16,431	11,168	5,388	6,534
54.02 03440	MAMMOGRAPHY	74,677	23,335	18,556	1,145	2,614
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01 03480	ONCOLOGY	0	0	0	0	0
56.00 05600	RADIOISOTOPE	364,188	8,992	6,071	2,341	7,187
57.00 05700	CT SCAN	606,134	17,066	4,763	7,933	10,454
58.00 05800	MRI	220,514	11,418	128,705	2,919	4,574
59.00 05900	CARDIAC CATHETERIZATION	3,949,743	60,421	1,208,859	22,351	11,761
60.00 06000	LABORATORY	4,778,580	84,182	212,270	0	33,977
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	467,211	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,314,999	44,294	38,757	18,825	20,256
66.00 06600	PHYSICAL THERAPY	850,825	25,928	1,986	0	1,960
67.00 06700	OCCUPATIONAL THERAPY	772,078	16,813	1,939	0	1,307
68.00 06800	SPEECH PATHOLOGY	233,747	1,372	636	0	653
69.01 03140	CARDIOLOGY	570,593	18,547	68,588	7,900	9,801
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,162,660	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,482,036	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	3,095,882	0	0	0	0
74.00 07400	RENAL DIALYSIS	463,673	3,069	505	2,751	1,960
76.97 07697	CARDIAC REHABILITATION	442,085	22,367	16,292	6,831	2,614
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,065,588	80,051	122,561	43,989	36,591
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,993,069	0	115,010	38,096	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

Worksheet B
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	4.00	5.01		
118.00	SUBTOTALS (SUM OF LINES 1-117)	118,582,007	2,551,815	5,354,595	694,724	683,461	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	192,769	12,126	3,906	951	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,427,658	16,835	12,127	17,822	13,721	192.00
192.01	19201 COVENANT OUTPATIENT PHARMACY	768,760	5,352	6,752	3,585	3,267	192.01
192.02	19202 REAL ESTATE	-490,533	0	65,835	0	0	192.02
192.03	19203 FOUNDATION	92,619	0	45,072	21	3,920	192.03
192.04	19204 OUTREACH PROGRAMS	89,129	59,619	1,376	1,171	3,267	192.04
192.05	19205 UNASSIGNED	203,812	80,362	0	914	0	192.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	121,866,221	2,726,109	5,489,663	719,188	707,636	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			DATA PROCESSING	PURCH, RCVING, S TORING	ADMI TTING	CASHI ERING, A/R	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONE						5.01
5.02	00550	DATA PROCESSING	0					5.02
5.03	00560	PURCH, RCVING, STORING	0	0				5.03
5.04	00570	ADMI TTING	0	0	800,674			5.04
5.05	00580	CASHI ERING, A/R	0	0	0	57,274		5.05
5.06	00590	OTHER ADMIN & GEN	0	0	0	0	24,343,469	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	6,452,969	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	680,338	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,610,246	9.00
10.00	01000	DIETARY	0	0	0	0	505,988	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,059,253	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,177,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	701,940	14.00
15.00	01500	PHARMACY	0	0	0	0	2,054,502	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,673,038	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	903,798	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	763,482	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	886,673	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	72,031	5,128	11,307,378	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	20,364	1,450	3,267,518	31.00
41.00	04100	SUBPROVIDER - I&R	0	0	10,604	755	2,548,117	41.00
43.00	04300	NURSERY	0	0	4,328	308	518,738	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	96,107	6,843	10,838,532	50.00
50.01	03330	ENDOSCOPY	0	0	25,198	1,794	1,420,171	50.01
51.00	05100	RECOVERY ROOM	0	0	10,886	775	788,667	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,516	393	1,625,187	52.00
53.00	05300	ANESTHESIOLOGY	0	0	37,557	2,674	2,359,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,405	883	1,215,805	54.00
54.01	03630	ULTRASOUND	0	0	5,909	421	413,028	54.01
54.02	03440	MAMMOGRAPHY	0	0	1,047	75	121,449	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	4,827	344	393,950	56.00
57.00	05700	CT SCAN	0	0	35,311	2,514	684,175	57.00
58.00	05800	MRI	0	0	9,925	707	378,762	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	39,888	2,840	5,295,863	59.00
60.00	06000	LABORATORY	0	0	72,021	5,128	5,186,158	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,624	187	470,022	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	27,538	1,961	1,466,630	65.00
66.00	06600	PHYSICAL THERAPY	0	0	8,866	631	890,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,866	489	799,492	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,340	95	237,843	68.00
69.01	03140	CARDIOLOGY	0	0	12,112	862	688,403	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	32,368	2,304	4,197,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	43,732	3,114	5,528,882	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	121,621	8,926	3,226,429	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,299	93	473,350	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,589	113	491,891	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	60,906	4,336	3,414,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	15,889	1,131	4,163,195	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	800,674	57,274	118,224,006	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	209,752	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,488,163	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	0	0	0	0	787,716	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

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Cost Center Description			DATA PROCESSING	PURCH, RCVING, S TORING	ADMINISTRATIVE	CASHIERING, A/R	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
192.02	19202	REAL ESTATE	0	0	0	0	-424,698	192.02
192.03	19203	FOUNDATION	0	0	0	0	141,632	192.03
192.04	19204	OUTREACH PROGRAMS	0	0	0	0	154,562	192.04
192.05	19205	UNASSIGNED	0	0	0	0	285,088	192.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	800,674	57,274	121,866,221	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/24/2017 1:24 pm				
Cost Center Description		OTHER ADMIN & GEN 5.06	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 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		
5.01	00540	NONPATIENT TELEPHONE				5.01		
5.02	00550	DATA PROCESSING				5.02		
5.03	00560	PURCH, RCVI NG, STORI NG				5.03		
5.04	00570	ADMI TTI NG				5.04		
5.05	00580	CASHI ERI NG, A/R				5.05		
5.06	00590	OTHER ADMIN & GEN	24,343,469			5.06		
6.00	00600	MAI NTENANCE & REPAI RS	0	0		6.00		
7.00	00700	OPERATI ON OF PLANT	1,603,795	0	8,056,764	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	169,088	0	28,713	878,139	8.00	
9.00	00900	HOUSEKEEPING	400,204	0	130,583	0	2,141,033	9.00
10.00	01000	DI ETARY	125,756	0	339,309	0	91,988	10.00
11.00	01100	CAFETERIA	263,263	0	76,107	0	20,633	11.00
12.00	01200	MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSI NG ADMI NI STRATI ON	541,225	0	14,106	0	3,824	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	174,457	0	389,978	70,318	105,724	14.00
15.00	01500	PHARMACY	510,618	0	100,748	0	27,313	15.00
16.00	01600	MEDI CAL RECORDS & LI BRARY	415,810	0	245,112	0	66,451	16.00
17.00	01700	SOCI AL SERVI CE	224,626	0	18,532	0	5,024	17.00
19.00	01900	NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000	NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100	I & R SERVI CES-SALARY & FRINGES APPRV	189,753	0	0	0	0	21.00
22.00	02200	I & R SERVI CES-OTHER PRGM COSTS APPRV	220,370	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECI FY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDI ATRI CS	2,810,292	0	1,860,736	216,821	504,453	30.00
31.00	03100	INTENSI VE CARE UNI T	812,096	0	299,765	46,399	81,267	31.00
41.00	04100	SUBPROVI DER - I RF	633,299	0	390,450	61,406	105,852	41.00
43.00	04300	NURSERY	128,925	0	113,172	2,121	30,681	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATI NG ROOM	2,693,765	0	812,948	124,308	220,393	50.00
50.01	03330	ENDOSCOPY	352,964	0	130,140	40,531	35,281	50.01
51.00	05100	RECOVERY ROOM	196,012	0	70,529	15,192	19,121	51.00
52.00	05200	DELI VERY ROOM & LABOR ROOM	403,917	0	284,213	45,715	77,051	52.00
53.00	05300	ANESTHESI OLOGY	586,414	0	11,922	0	3,232	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	302,171	0	253,021	10,155	68,595	54.00
54.01	03630	ULTRASOUND	102,652	0	67,136	3,898	18,201	54.01
54.02	03440	MAMMOGRAPHY	30,184	0	95,348	1,387	25,849	54.02
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	0	55.01
56.00	05600	RADI OI SOTOPE	97,911	0	36,740	4,447	9,960	56.00
57.00	05700	CT SCAN	170,042	0	69,733	6,308	18,905	57.00
58.00	05800	MRI	94,136	0	46,656	2,718	12,649	58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	1,316,213	0	246,883	39,018	66,931	59.00
60.00	06000	LABORATORY	1,288,947	0	343,971	0	93,252	60.00
62.30	06250	BLOOD CLOTTI NG FOR HEMOPHI LI ACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORI NG, PROCESSI NG & TRANS.	116,817	0	0	0	0	63.00
65.00	06500	RESPI RATORY THERAPY	364,510	0	180,986	0	49,066	65.00
66.00	06600	PHYSI CAL THERAPY	221,246	0	105,942	2,714	28,721	66.00
67.00	06700	OCCUPATI ONAL THERAPY	198,703	0	68,700	2,650	18,625	67.00
68.00	06800	SPEECH PATHOLOGY	59,113	0	5,607	870	1,520	68.00
69.01	03140	CARDI OLOGY	171,093	0	75,782	7,380	20,545	69.01
71.00	07100	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1,043,188	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATI ENTS	1,374,126	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATI ENTS	801,884	0	0	0	0	73.00
74.00	07400	RENAL DI ALYSI S	117,645	0	12,542	1,642	3,400	74.00
76.97	07697	CARDI AC REHABI LI TATI ON	122,253	0	91,393	1,525	24,777	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	848,507	0	327,091	145,298	88,676	91.00
92.00	09200	OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVI CES	1,034,704	0	0	25,306	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,332,694	0	7,344,594	878,127	1,947,960	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	52,131	0	49,548	0	13,433	190.00
192.00	19200	PHYSI CI ANS' PRI VATE OFFI CES	618,398	0	68,788	0	18,649	192.00
192.01	19201	COVENANT OUTPATI ENT PHARMACY	195,776	0	21,867	0	5,928	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			OTHER ADMIN & GEN	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
192.02	19202	REAL ESTATE	0	0	0	0	0	192.02
192.03	19203	FOUNDATION	35,201	0	0	0	0	192.03
192.04	19204	OUTREACH PROGRAMS	38,414	0	243,607	12	66,043	192.04
192.05	19205	UNASSIGNED	70,855	0	328,360	0	89,020	192.05
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)	24,343,469	0	8,056,764	878,139	2,141,033	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/24/2017 1:24 pm			
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCH, RCVING, STORING						5.03
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING, A/R						5.05
5.06	00590	OTHER ADMIN & GEN						5.06
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	1,063,041					10.00
11.00	01100	CAFETERIA	0	1,419,256				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	48,086	0	2,784,892		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,158	0	2,759	1,446,334	14.00
15.00	01500	PHARMACY	0	30,959	0	73,743	2,094	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,456	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	18,546	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	721,630	408,829	0	973,808	12,547	30.00
31.00	03100	INTENSIVE CARE UNIT	122,157	94,149	0	224,258	4,957	31.00
41.00	04100	SUBPROVIDER - I RF	160,610	61,739	0	147,058	1,652	41.00
43.00	04300	NURSERY	58,644	19,672	0	46,856	1,160	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	139,919	0	333,279	310,871	50.00
50.01	03330	ENDOSCOPY	0	32,199	0	76,695	19	50.01
51.00	05100	RECOVERY ROOM	0	19,900	0	47,400	266	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	46,031	0	109,643	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,631	0	3,885	134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,629	0	82,485	105	54.00
54.01	03630	ULTRASOUND	0	10,309	0	24,555	2,004	54.01
54.02	03440	MAMMOGRAPHY	0	1,354	0	3,225	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	7,503	0	17,872	17,819	56.00
57.00	05700	CT SCAN	0	15,284	0	36,405	5,363	57.00
58.00	05800	MRI	0	7,878	0	18,766	422	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	47,238	0	112,518	184,932	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	41,092	63.00
65.00	06500	RESPIRATORY THERAPY	0	51,120	0	121,765	4	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	244	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.01	03140	CARDIOLOGY	0	15,904	0	37,881	552	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	366,326	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	483,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,496	0	5,944	111	74.00
76.97	07697	CARDIAC REHABILITATION	0	10,211	0	24,322	317	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	109,058	0	259,770	995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	145,579	0	0	7,980	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,063,041	1,391,837	0	2,784,892	1,445,130	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,822	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,628	0	0	1,171	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

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Part I
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Cost Center Description		DI ETARY	CAFETERIA	MAI NTENANCE OF PERSONNEL	NURSI NG ADMINI STRATION	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
192.01	19201 COVENANT OUTPATIENT PHARMACY	0	3,474	0	0	0	192.01
192.02	19202 REAL ESTATE	0	0	0	0	7	192.02
192.03	19203 FOUNDATION	0	326	0	0	0	192.03
192.04	19204 OUTREACH PROGRAMS	0	2,169	0	0	26	192.04
192.05	19205 UNASSIGNED	0	0	0	0	0	192.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,063,041	1,419,256	0	2,784,892	1,446,334	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

Worksheet B
Part I
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
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						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	2,799,977					15.00
16.00	01600	0	2,410,867				16.00
17.00	01700	0	0	1,170,526			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0		21.00
22.00	02200	0	0	0	0		22.00
23.00	02300	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,292	216,793	745,741	0	0	30.00
31.00	03100	9,909	61,289	126,417	0	0	31.00
41.00	04100	578	31,916	166,215	0	0	41.00
43.00	04300	4	13,025	61,921	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	42,015	289,254	0	0	0	50.00
50.01	03330	24,291	75,838	0	0	0	50.01
51.00	05100	63	32,765	0	0	0	51.00
52.00	05200	8,659	16,602	0	0	0	52.00
53.00	05300	2,114	113,035	0	0	0	53.00
54.00	05400	7,388	37,335	0	0	0	54.00
54.01	03630	2,508	17,786	0	0	0	54.01
54.02	03440	1,272	3,152	0	0	0	54.02
55.00	05500	0	0	0	0	0	55.00
55.01	03480	0	0	0	0	0	55.01
56.00	05600	260	14,526	0	0	0	56.00
57.00	05700	20,029	106,277	0	0	0	57.00
58.00	05800	13,624	29,872	0	0	0	58.00
59.00	05900	20,594	120,052	0	0	0	59.00
60.00	06000	0	216,762	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	7,896	0	0	0	63.00
65.00	06500	6	82,880	0	0	0	65.00
66.00	06600	0	26,683	0	0	0	66.00
67.00	06700	0	20,665	0	0	0	67.00
68.00	06800	0	4,033	0	0	0	68.00
69.01	03140	36,101	36,453	0	0	0	69.01
71.00	07100	150,447	97,417	0	0	0	71.00
72.00	07200	0	131,619	0	0	0	72.00
73.00	07300	2,384,306	367,118	0	0	0	73.00
74.00	07400	32	3,910	0	0	0	74.00
76.97	07697	0	4,783	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	43,042	183,310	70,232	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	11,634	47,821	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,785,168	2,410,867	1,170,526	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	14,809	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
192.01	19201 COVENANT OUTPATIENT PHARMACY	0	0	0	0	0	0 192.01
192.02	19202 REAL ESTATE	0	0	0	0	0	0 192.02
192.03	19203 FOUNDATION	0	0	0	0	0	0 192.03
192.04	19204 OUTREACH PROGRAMS	0	0	0	0	0	0 192.04
192.05	19205 UNASSIGNED	0	0	0	0	0	0 192.05
200.00	Cross Foot Adjustments						0 200.00
201.00	Negative Cost Centers	0	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	2,799,977	2,410,867	1,170,526	0	0	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

Worksheet B
Part I
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONE						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00560 PURCH, RCVING, STORING						5.03
5.04 00570 ADMIN TTING						5.04
5.05 00580 CASHIERING, A/R						5.05
5.06 00590 OTHER ADMIN & GEN						5.06
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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000 NURSING SCHOOL						20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	953,235					21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		1,107,043				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	803,196	932,794	0	21,521,310	-1,735,990	30.00
31.00 03100 INTENSIVE CARE UNIT	42,991	49,928	0	5,243,100	-92,919	31.00
41.00 04100 SUBPROVIDER - I&R	0	0	0	4,308,892	0	41.00
43.00 04300 NURSERY	0	0	0	994,919	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	15,805,284	0	50.00
50.01 03330 ENDOSCOPY	64,343	74,725	0	2,327,197	-139,068	50.01
51.00 05100 RECOVERY ROOM	0	0	0	1,189,915	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	2,617,018	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	3,081,841	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	2,011,689	0	54.00
54.01 03630 ULTRASOUND	0	0	0	662,077	0	54.01
54.02 03440 MAMMOGRAPHY	0	0	0	283,220	0	54.02
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 03480 ONCOLOGY	0	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	0	0	0	600,988	0	56.00
57.00 05700 CT SCAN	0	0	0	1,132,521	0	57.00
58.00 05800 MRI	0	0	0	605,483	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	7,450,242	0	59.00
60.00 06000 LABORATORY	0	0	0	7,129,090	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	635,827	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	2,316,967	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	1,275,746	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,108,835	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	308,986	0	68.00
69.01 03140 RADIOLOGY	42,705	49,596	0	1,182,395	-92,301	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,854,710	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,517,791	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	6,779,737	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	621,072	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	771,472	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	5,490,001	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	5,436,219	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV						
	21.00	22.00						
118.00	SUBTOTALS (SUM OF LINES 1-117)		953,235	1,107,043	0	116,264,544	-2,060,278	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	327,686	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	3,228,606	0	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	0	0	0	1,014,761	0	192.01
192.02	19202	REAL ESTATE	0	0	0	-424,691	0	192.02
192.03	19203	FOUNDATION	0	0	0	177,159	0	192.03
192.04	19204	OUTREACH PROGRAMS	0	0	0	504,833	0	192.04
192.05	19205	UNASSIGNED	0	0	0	773,323	0	192.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	953,235	1,107,043	0	121,866,221	-2,060,278	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/24/2017 1:24 pm
Cost Center Description		Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONE		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCH, RCVING, STORING		5.03
5.04	00570	ADMINISTRATIVE		5.04
5.05	00580	CASHIERING, A/R		5.05
5.06	00590	OTHER ADMIN & GEN		5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	19,785,320	30.00
31.00	03100	INTENSIVE CARE UNIT	5,150,181	31.00
41.00	04100	SUBPROVIDER - I&R	4,308,892	41.00
43.00	04300	NURSERY	994,919	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	15,805,284	50.00
50.01	03330	ENDOSCOPY	2,188,129	50.01
51.00	05100	RECOVERY ROOM	1,189,915	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,617,018	52.00
53.00	05300	ANESTHESIOLOGY	3,081,841	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,011,689	54.00
54.01	03630	ULTRASOUND	662,077	54.01
54.02	03440	MAMMOGRAPHY	283,220	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
55.01	03480	ONCOLOGY	0	55.01
56.00	05600	RADIOISOTOPE	600,988	56.00
57.00	05700	CT SCAN	1,132,521	57.00
58.00	05800	MRI	605,483	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,450,242	59.00
60.00	06000	LABORATORY	7,129,090	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	635,827	63.00
65.00	06500	RESPIRATORY THERAPY	2,316,967	65.00
66.00	06600	PHYSICAL THERAPY	1,275,746	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,108,835	67.00
68.00	06800	SPEECH PATHOLOGY	308,986	68.00
69.01	03140	CARDIOLOGY	1,090,094	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,854,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,517,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,779,737	73.00
74.00	07400	RENAL DIALYSIS	621,072	74.00
76.97	07697	CARDIAC REHABILITATION	771,472	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	5,490,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	5,436,219	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	114,204,266	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	327,686	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,228,606	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	1,014,761	192.01
192.02	19202	REAL ESTATE	-424,691	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0113

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description			Total	
			26.00	
192.03	19203	FOUNDATION	177,159	192.03
192.04	19204	OUTREACH PROGRAMS	504,833	192.04
192.05	19205	UNASSIGNED	773,323	192.05
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	119,805,943	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	1,401	0	1,401	4.00
5.01 00540	NONPATIENT TELEPHONE	0	5,265	22,621	27,886	5.01
5.02 00550	DATA PROCESSING	0	0	0	0	5.02
5.03 00560	PURCH, RCVING, STORING	0	0	0	0	5.03
5.04 00570	ADMITTING	0	15,506	6,453	21,959	5.04
5.05 00580	CASHIERING, A/R	0	2,073	0	2,073	5.05
5.06 00590	OTHER ADMIN & GEN	0	154,476	174,185	328,661	5.06
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	575,610	795,126	1,370,736	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,027	520	7,547	8.00
9.00 00900	HOUSEKEEPING	0	31,958	9,654	41,612	9.00
10.00 01000	DIETARY	0	83,041	1,827	84,868	10.00
11.00 01100	CAFETERIA	0	18,626	3,759	22,385	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	3,452	342,722	346,174	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	95,441	187,060	282,501	14.00
15.00 01500	PHARMACY	0	24,657	15,077	39,734	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	59,988	612	60,600	16.00
17.00 01700	SOCIAL SERVICE	0	4,536	0	4,536	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	455,389	123,247	578,636	30.00
31.00 03100	INTENSIVE CARE UNIT	0	73,363	91,024	164,387	31.00
41.00 04100	SUBPROVIDER - IRF	0	95,557	21,425	116,982	41.00
43.00 04300	NURSERY	0	27,697	6,465	34,162	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	198,957	1,183,257	1,382,214	50.00
50.01 03330	ENDOSCOPY	0	31,850	34,542	66,392	50.01
51.00 05100	RECOVERY ROOM	0	17,261	72,442	89,703	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	69,557	190,873	260,430	52.00
53.00 05300	ANESTHESIOLOGY	0	2,918	14,690	17,608	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	61,923	100,348	162,271	54.00
54.01 03630	ULTRASOUND	0	16,431	11,168	27,599	54.01
54.02 03440	MAMMOGRAPHY	0	23,335	18,556	41,891	54.02
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01 03480	ONCOLOGY	0	0	0	0	55.01
56.00 05600	RADIOISOTOPE	0	8,992	6,071	15,063	56.00
57.00 05700	CT SCAN	0	17,066	4,763	21,829	57.00
58.00 05800	MRI	0	11,418	128,705	140,123	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	60,421	1,208,859	1,269,280	59.00
60.00 06000	LABORATORY	0	84,182	212,270	296,452	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	0	44,294	38,757	83,051	65.00
66.00 06600	PHYSICAL THERAPY	0	25,928	1,986	27,914	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	16,813	1,939	18,752	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,372	636	2,008	68.00
69.01 03140	CARDIOLOGY	0	18,547	68,588	87,135	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	3,069	505	3,574	74.00
76.97 07697	CARDIAC REHABILITATION	0	22,367	16,292	38,659	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	80,051	122,561	202,612	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	115,010	115,010	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,551,815	5,354,595	7,906,410	1,354

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0113

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,126	3,906	16,032		2 190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	16,835	12,127	28,962		34 192.00
192.01 19201 COVENANT OUTPATIENT PHARMACY	0	5,352	6,752	12,104		7 192.01
192.02 19202 REAL ESTATE	0	0	65,835	65,835		0 192.02
192.03 19203 FOUNDATION	0	0	45,072	45,072		0 192.03
192.04 19204 OUTREACH PROGRAMS	0	59,619	1,376	60,995		2 192.04
192.05 19205 UNASSIGNED	0	80,362	0	80,362		2 192.05
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)	0	2,726,109	5,489,663	8,215,772		1,401 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm		
Cost Center Description			NONPATIENT TELEPHONE	DATA PROCESSING	PURCH, RCVING, STORING	ADMINISTRATIVE	CASHIERING, A/R
			5.01	5.02	5.03	5.04	5.05
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONE	27,895				5.01
5.02	00550	DATA PROCESSING	0	0			5.02
5.03	00560	PURCH, RCVING, STORING	0	0	0		5.03
5.04	00570	ADMINISTRATIVE	670	0	0	22,649	5.04
5.05	00580	CASHIERING, A/R	103	0	0	0	5.05
5.06	00590	OTHER ADMIN & GEN	5,795	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	567	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52	0	0	0	8.00
9.00	00900	HOUSEKEEPING	206	0	0	0	9.00
10.00	01000	DIETARY	361	0	0	0	10.00
11.00	01100	CAFETERIA	773	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	180	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	438	0	0	0	14.00
15.00	01500	PHARMACY	670	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	824	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	386	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	26	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,095	0	0	2,040	175
31.00	03100	INTENSIVE CARE UNIT	489	0	0	577	49
41.00	04100	SUBPROVIDER - I&R	1,159	0	0	300	26
43.00	04300	NURSERY	309	0	0	123	11
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,520	0	0	2,721	233
50.01	03330	ENDOSCOPY	489	0	0	714	61
51.00	05100	RECOVERY ROOM	567	0	0	308	26
52.00	05200	DELIVERY ROOM & LABOR ROOM	515	0	0	156	13
53.00	05300	ANESTHESIOLOGY	77	0	0	1,064	91
54.00	05400	RADIOLOGY-DIAGNOSTIC	670	0	0	351	30
54.01	03630	ULTRASOUND	258	0	0	167	14
54.02	03440	MAMMOGRAPHY	103	0	0	30	3
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01	03480	ONCOLOGY	0	0	0	0	0
56.00	05600	RADIOISOTOPE	283	0	0	137	12
57.00	05700	CT SCAN	412	0	0	1,000	86
58.00	05800	MRI	180	0	0	281	24
59.00	05900	CARDIAC CATHETERIZATION	464	0	0	1,130	97
60.00	06000	LABORATORY	1,339	0	0	2,039	175
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	74	6
65.00	06500	RESPIRATORY THERAPY	798	0	0	780	67
66.00	06600	PHYSICAL THERAPY	77	0	0	251	22
67.00	06700	OCCUPATIONAL THERAPY	52	0	0	194	17
68.00	06800	SPEECH PATHOLOGY	26	0	0	38	3
69.01	03140	CARDIOLOGY	386	0	0	343	29
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	917	79
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,238	106
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,419	527
74.00	07400	RENAL DIALYSIS	77	0	0	37	3
76.97	07697	CARDIAC REHABILITATION	103	0	0	45	4
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,442	0	0	1,725	148
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	450	39
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,941	0	0	22,649	2,176
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	541	0	0	0	0
192.01	19201	COVENANT OUTPATIENT PHARMACY	129	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0113

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description			NONPATIENT TELEPHONE	DATA PROCESSING	PURCH, RCVING, S TORING	ADMINISTRATION	CASHIERING, A/R		
			5.01	5.02	5.03	5.04	5.05		
192.02	19202	REAL ESTATE	0	0	0	0	0	0	192.02
192.03	19203	FOUNDATION	155	0	0	0	0	0	192.03
192.04	19204	OUTREACH PROGRAMS	129	0	0	0	0	0	192.04
192.05	19205	UNASSIGNED	0	0	0	0	0	0	192.05
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,895	0	0	22,649	2,176	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm				
Cost Center Description		OTHER ADMIN & GEN	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.06	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		
5.01	00540	NONPATIENT TELEPHONE				5.01		
5.02	00550	DATA PROCESSING				5.02		
5.03	00560	PURCH, RCVI NG, STORING				5.03		
5.04	00570	ADMI TTING				5.04		
5.05	00580	CASHI ERING, A/R				5.05		
5.06	00590	OTHER ADMIN & GEN	334,555			5.06		
6.00	00600	MAI NTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATI ON OF PLANT	22,043	0	1,393,377	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	2,324	0	4,966	14,894	8.00	
9.00	00900	HOUSEKEEPING	5,501	0	22,584	0	69,936	9.00
10.00	01000	DI ETARY	1,728	0	58,682	0	3,005	10.00
11.00	01100	CAFETERIA	3,618	0	13,162	0	674	11.00
12.00	01200	MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSI NG ADMI NISTRATION	7,439	0	2,440	0	125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,398	0	67,445	1,193	3,453	14.00
15.00	01500	PHARMACY	7,018	0	17,424	0	892	15.00
16.00	01600	MEDI CAL RECORDS & LI BRARY	5,715	0	42,391	0	2,171	16.00
17.00	01700	SOCI AL SERVI CE	3,087	0	3,205	0	164	17.00
19.00	01900	NONPHYSICI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000	NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100	I & R SERVI CES-SALARY & FRINGES APPRV	2,608	0	0	0	0	21.00
22.00	02200	I & R SERVI CES-OTHER PRGM COSTS APPRV	3,029	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECI FY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDI ATRI CS	38,593	0	321,803	3,679	16,476	30.00
31.00	03100	INTENSI VE CARE UNI T	11,162	0	51,843	787	2,655	31.00
41.00	04100	SUBPROVI DER - I RF	8,704	0	67,526	1,041	3,458	41.00
43.00	04300	NURSERY	1,772	0	19,572	36	1,002	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATI NG ROOM	37,024	0	140,595	2,108	7,199	50.00
50.01	03330	ENDOSCOPY	4,851	0	22,507	687	1,152	50.01
51.00	05100	RECOVERY ROOM	2,694	0	12,198	258	625	51.00
52.00	05200	DELI VERY ROOM & LABOR ROOM	5,552	0	49,153	775	2,517	52.00
53.00	05300	ANESTHESI OLOGY	8,060	0	2,062	0	106	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	4,153	0	43,759	172	2,241	54.00
54.01	03630	ULTRASOUND	1,411	0	11,611	66	595	54.01
54.02	03440	MAMMOGRAPHY	415	0	16,490	24	844	54.02
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	0	55.01
56.00	05600	RADI OI SOTOPE	1,346	0	6,354	75	325	56.00
57.00	05700	CT SCAN	2,337	0	12,060	107	618	57.00
58.00	05800	MRI	1,294	0	8,069	46	413	58.00
59.00	05900	CARDI AC CATHETERI ZATION	18,091	0	42,697	662	2,186	59.00
60.00	06000	LABORATORY	17,716	0	59,488	0	3,046	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHI LI ACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,606	0	0	0	0	63.00
65.00	06500	RESPI RATORY THERAPY	5,010	0	31,301	0	1,603	65.00
66.00	06600	PHYSI CAL THERAPY	3,041	0	18,322	46	938	66.00
67.00	06700	OCCUPATI ONAL THERAPY	2,731	0	11,881	45	608	67.00
68.00	06800	SPEECH PATHOLOGY	812	0	970	15	50	68.00
69.01	03140	CARDI OLOGY	2,352	0	13,106	125	671	69.01
71.00	07100	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	14,338	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATI ENTS	18,887	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATI ENTS	11,021	0	0	0	0	73.00
74.00	07400	RENAL DI ALYSI S	1,617	0	2,169	28	111	74.00
76.97	07697	CARDI AC REHABI LI TATION	1,680	0	15,806	26	809	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	11,662	0	56,569	2,464	2,897	91.00
92.00	09200	OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVI CES	14,221	0	0	429	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LI NES 1-117)	320,661	0	1,270,210	14,894	63,629	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	717	0	8,569	0	439	190.00
192.00	19200	PHYSI CI ANS' PRI VATE OFFI CES	8,500	0	11,897	0	609	192.00
192.01	19201	COVENANT OUTPATI ENT PHARMACY	2,691	0	3,782	0	194	192.01

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm		
Cost Center Description			OTHER ADMIN & GEN	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
			5.06	6.00	7.00	8.00	9.00		
192.02	19202	REAL ESTATE	0	0	0	0	0	0	192.02
192.03	19203	FOUNDATION	484	0	0	0	0	0	192.03
192.04	19204	OUTREACH PROGRAMS	528	0	42,131	0	2,157	0	192.04
192.05	19205	UNASSIGNED	974	0	56,788	0	2,908	0	192.05
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	334,555	0	1,393,377	14,894	69,936	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCH, RCVING, STORING						5.03
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING, A/R						5.05
5.06	00590	OTHER ADMIN & GEN						5.06
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	148,649					10.00
11.00	01100	CAFETERIA	0	40,628				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,377	0	357,785		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33	0	354	357,816	14.00
15.00	01500	PHARMACY	0	886	0	9,474	518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	299	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	531	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100,908	11,705	0	125,107	3,104	30.00
31.00	03100	INTENSIVE CARE UNIT	17,082	2,695	0	28,811	1,226	31.00
41.00	04100	SUBPROVIDER - I&R	22,459	1,767	0	18,893	409	41.00
43.00	04300	NURSERY	8,200	563	0	6,020	287	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,005	0	42,818	76,907	50.00
50.01	03330	ENDOSCOPY	0	922	0	9,853	5	50.01
51.00	05100	RECOVERY ROOM	0	570	0	6,090	66	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,318	0	14,086	0	52.00
53.00	05300	ANESTHESIOLOGY	0	47	0	499	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	991	0	10,597	26	54.00
54.01	03630	ULTRASOUND	0	295	0	3,155	496	54.01
54.02	03440	MAMMOGRAPHY	0	39	0	414	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	215	0	2,296	4,408	56.00
57.00	05700	CT SCAN	0	438	0	4,677	1,327	57.00
58.00	05800	MRI	0	226	0	2,411	104	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,352	0	14,456	45,751	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	10,166	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,463	0	15,644	1	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	60	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.01	03140	CARDIOLOGY	0	455	0	4,867	137	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	90,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	119,535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	71	0	764	27	74.00
76.97	07697	CARDIAC REHABILITATION	0	292	0	3,125	78	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	3,122	0	33,374	246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	4,167	0	0	1,974	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	148,649	39,844	0	357,785	357,518	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	81	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	533	0	0	290	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0113

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

Worksheet B
Part II
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Cost Center Description		DI ETARY	CAFETERIA	MAI NTENANCE OF PERSONNEL	NURSI NG ADMINI STRATION	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
192.01	19201 COVENANT OUTPATIENT PHARMACY	0	99	0	0	0	192.01
192.02	19202 REAL ESTATE	0	0	0	0	2	192.02
192.03	19203 FOUNDATION	0	9	0	0	0	192.03
192.04	19204 OUTREACH PROGRAMS	0	62	0	0	6	192.04
192.05	19205 UNASSIGNED	0	0	0	0	0	192.05
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)	148,649	40,628	0	357,785	357,816	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCH, RCVING, STORING						5.03
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING, A/R						5.05
5.06	00590	OTHER ADMIN & GEN						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	76,672					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	112,007				16.00
17.00	01700	SOCIAL SERVICE	0	0	11,935			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	172	10,082	7,604			30.00
31.00	03100	INTENSIVE CARE UNIT	271	2,850	1,289			31.00
41.00	04100	SUBPROVIDER - I&R	16	1,484	1,695			41.00
43.00	04300	NURSERY	0	606	631			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,151	13,452	0			50.00
50.01	03330	ENDOSCOPY	665	3,527	0			50.01
51.00	05100	RECOVERY ROOM	2	1,524	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237	772	0			52.00
53.00	05300	ANESTHESIOLOGY	58	5,257	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202	1,736	0			54.00
54.01	03630	ULTRASOUND	69	827	0			54.01
54.02	03440	MAMMOGRAPHY	35	147	0			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0			55.00
55.01	03480	ONCOLOGY	0	0	0			55.01
56.00	05600	RADIOISOTOPE	7	676	0			56.00
57.00	05700	CT SCAN	548	4,942	0			57.00
58.00	05800	MRI	373	1,389	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	564	5,583	0			59.00
60.00	06000	LABORATORY	0	10,081	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	367	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	3,854	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,241	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	961	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	188	0			68.00
69.01	03140	CARDIOLOGY	989	1,695	0			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,120	4,530	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,121	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,288	16,962	0			73.00
74.00	07400	RENAL DIALYSIS	1	182	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	222	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,179	8,525	716			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	319	2,224	0			95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,266	112,007	11,935	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	406	0	0			192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0113

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

Worksheet B
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
192.01	19201 COVENANT OUTPATIENT PHARMACY	0	0	0			192.01
192.02	19202 REAL ESTATE	0	0	0			192.02
192.03	19203 FOUNDATION	0	0	0			192.03
192.04	19204 OUTREACH PROGRAMS	0	0	0			192.04
192.05	19205 UNASSIGNED	0	0	0			192.05
200.00	Cross Foot Adjustments				0		0 200.00
201.00	Negative Cost Centers	0	0	0	0		0 201.00
202.00	TOTAL (sum lines 118-201)	76,672	112,007	11,935	0		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0113

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

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Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					
	21.00	22.00	23.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540	NONPATIENT TELEPHONE						5.01
5.02 00550	DATA PROCESSING						5.02
5.03 00560	PURCH, RCVING, STORING						5.03
5.04 00570	ADMINISTRATIVE						5.04
5.05 00580	CASHIERING, A/R						5.05
5.06 00590	OTHER ADMIN & GEN						5.06
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
12.00 01200	MAINTENANCE OF PERSONNEL						12.00
13.00 01300	NURSING ADMINISTRATION						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY						14.00
15.00 01500	PHARMACY						15.00
16.00 01600	MEDICAL RECORDS & LIBRARY						16.00
17.00 01700	SOCIAL SERVICE						17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000	NURSING SCHOOL						20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	2,634					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		3,029				22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS				1,224,483	0	30.00
31.00 03100	INTENSIVE CARE UNIT				286,251	0	31.00
41.00 04100	SUBPROVIDER - I&F				245,966	0	41.00
43.00 04300	NURSERY				73,307	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM				1,712,076	0	50.00
50.01 03330	ENDOSCOPY				111,854	0	50.01
51.00 05100	RECOVERY ROOM				114,651	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM				335,562	0	52.00
53.00 05300	ANESTHESIOLOGY				34,963	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				227,227	0	54.00
54.01 03630	ULTRASOUND				46,573	0	54.01
54.02 03440	MAMMOGRAPHY				60,437	0	54.02
55.00 05500	RADIOLOGY-THERAPEUTIC				0	0	55.00
55.01 03480	ONCOLOGY				0	0	55.01
56.00 05600	RADIOISOTOPE				31,202	0	56.00
57.00 05700	CT SCAN				50,396	0	57.00
58.00 05800	MRI				154,939	0	58.00
59.00 05900	CARDIAC CATHETERIZATION				1,402,356	0	59.00
60.00 06000	LABORATORY				390,336	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.				12,219	0	63.00
65.00 06500	RESPIRATORY THERAPY				143,608	0	65.00
66.00 06600	PHYSICAL THERAPY				51,912	0	66.00
67.00 06700	OCCUPATIONAL THERAPY				35,241	0	67.00
68.00 06800	SPEECH PATHOLOGY				4,110	0	68.00
69.01 03140	CARDIOLOGY				112,305	0	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT				114,611	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				145,887	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				97,217	0	73.00
74.00 07400	RENAL DIALYSIS				8,666	0	74.00
76.97 07697	CARDIAC REHABILITATION				60,862	0	76.97
76.98 07698	HYPERBARIIC OXYGEN THERAPY				0	0	76.98
76.99 07699	LI THOTRI PSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY				326,766	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES				138,907	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0113

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

Worksheet B
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Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					
	21.00	22.00	23.00				
118.00	SUBTOTALS (SUM OF LINES 1-117)			0	7,754,890	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			25,840	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			51,772	0	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY			19,006	0	192.01
192.02	19202	REAL ESTATE			65,837	0	192.02
192.03	19203	FOUNDATION			45,720	0	192.03
192.04	19204	OUTREACH PROGRAMS			106,010	0	192.04
192.05	19205	UNASSIGNED			141,034	0	192.05
200.00		Cross Foot Adjustments	2,634	3,029	0	5,663	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,634	3,029	0	8,215,772	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm
Cost Center Description		Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.01	00540			5.01
5.02	00550			5.02
5.03	00560			5.03
5.04	00570			5.04
5.05	00580			5.05
5.06	00590			5.06
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			11.00
12.00	01200			12.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700			17.00
19.00	01900			19.00
20.00	02000			20.00
21.00	02100			21.00
22.00	02200			22.00
23.00	02300			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	1,224,483		30.00
31.00	03100	286,251		31.00
41.00	04100	245,966		41.00
43.00	04300	73,307		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	1,712,076		50.00
50.01	03330	111,854		50.01
51.00	05100	114,651		51.00
52.00	05200	335,562		52.00
53.00	05300	34,963		53.00
54.00	05400	227,227		54.00
54.01	03630	46,573		54.01
54.02	03440	60,437		54.02
55.00	05500	0		55.00
55.01	03480	0		55.01
56.00	05600	31,202		56.00
57.00	05700	50,396		57.00
58.00	05800	154,939		58.00
59.00	05900	1,402,356		59.00
60.00	06000	390,336		60.00
62.30	06250	0		62.30
63.00	06300	12,219		63.00
65.00	06500	143,608		65.00
66.00	06600	51,912		66.00
67.00	06700	35,241		67.00
68.00	06800	4,110		68.00
69.01	03140	112,305		69.01
71.00	07100	114,611		71.00
72.00	07200	145,887		72.00
73.00	07300	97,217		73.00
74.00	07400	8,666		74.00
76.97	07697	60,862		76.97
76.98	07698	0		76.98
76.99	07699	0		76.99
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	326,766		91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	138,907		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
118.00		7,754,890		118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	25,840		190.00
192.00	19200	51,772		192.00
192.01	19201	19,006		192.01
192.02	19202	65,837		192.02

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description			Total	
			26.00	
192.03	19203	FOUNDATION	45,720	192.03
192.04	19204	OUTREACH PROGRAMS	106,010	192.04
192.05	19205	UNASSIGNED	141,034	192.05
200.00		Cross Foot Adjustments	5,663	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	8,215,772	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONE (N LINES)	DATA PROCESSING (N DEVICES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	377,462				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,313,198			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	194	0	37,624,971		4.00
5.01 00540	NONPATIENT TELEPHONE	729	9,532	256,239	1,083	5.01
5.02 00550	DATA PROCESSING	0	0	0	0	5.02
5.03 00560	PURCH, RCVING, STORING	0	0	0	0	5.03
5.04 00570	ADMINISTRATIVE	2,147	2,719	548,128	26	5.04
5.05 00580	CASHIERING, A/R	287	0	0	4	5.05
5.06 00590	OTHER ADMIN & GEN	21,389	73,397	2,669,345	225	5.06
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	79,700	335,045	848,066	22	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	973	219	130,549	2	8.00
9.00 00900	HOUSEKEEPING	4,425	4,068	886,663	8	9.00
10.00 01000	DIETARY	11,498	770	131,021	14	10.00
11.00 01100	CAFETERIA	2,579	1,584	419,846	30	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	478	144,414	1,345,574	7	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	13,215	78,822	36,546	17	14.00
15.00 01500	PHARMACY	3,414	6,353	1,505,194	26	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	8,306	258	177,929	32	16.00
17.00 01700	SOCIAL SERVICE	628	0	690,210	15	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	63,054	51,933	7,924,134	159	30.00
31.00 03100	INTENSIVE CARE UNIT	10,158	38,355	2,097,089	19	31.00
41.00 04100	SUBPROVIDER - I&R	13,231	9,028	1,283,595	45	41.00
43.00 04300	NURSERY	3,835	2,724	359,272	12	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	27,548	498,593	3,485,178	59	50.00
50.01 03330	ENDOSCOPY	4,410	14,555	787,235	19	50.01
51.00 05100	RECOVERY ROOM	2,390	30,525	549,407	22	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,631	80,429	1,039,701	20	52.00
53.00 05300	ANESTHESIOLOGY	404	6,190	31,003	3	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,574	42,284	748,320	26	54.00
54.01 03630	ULTRASOUND	2,275	4,706	281,869	10	54.01
54.02 03440	MAMMOGRAPHY	3,231	7,819	59,903	4	54.02
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01 03480	ONCOLOGY	0	0	0	0	55.01
56.00 05600	RADIOISOTOPE	1,245	2,558	122,493	11	56.00
57.00 05700	CT SCAN	2,363	2,007	415,027	16	57.00
58.00 05800	MRI	1,581	54,233	152,720	7	58.00
59.00 05900	CARDIAC CATHETERIZATION	8,366	509,381	1,169,307	18	59.00
60.00 06000	LABORATORY	11,656	89,445	0	52	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	6,133	16,331	984,838	31	65.00
66.00 06600	PHYSICAL THERAPY	3,590	837	0	3	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,328	817	0	2	67.00
68.00 06800	SPEECH PATHOLOGY	190	268	0	1	68.00
69.01 03140	CARDIOLOGY	2,568	28,901	413,263	15	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	425	213	143,900	3	74.00
76.97 07697	CARDIAC REHABILITATION	3,097	6,865	357,349	4	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	11,084	51,644	2,301,270	56	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	48,462	1,992,985	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONE (N LINES)	DATA PROCESSING (N DEVICES)			
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00					4.00	5.01
118.00	SUBTOTALS (SUM OF LINES 1-117)					0	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,679	1,646	49,758	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,331	5,110	932,333	21	0	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	741	2,845	187,549	5	0	192.01
192.02	19202	REAL ESTATE	0	27,741	0	0	0	192.02
192.03	19203	FOUNDATION	0	18,992	1,111	6	0	192.03
192.04	19204	OUTREACH PROGRAMS	8,255	580	61,245	5	0	192.04
192.05	19205	UNASSIGNED	11,127	0	47,807	0	0	192.05
200.00	Cross Foot Adjustments						0	200.00
201.00	Negative Cost Centers						0	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		2,726,109	5,489,663	719,188	707,636	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		7.222208	2.373192	0.019115	653.403509	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				1,401	27,895	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000037	25.757156	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		PURCH, RCVI NG, S TORI NG (SUPPLI ES \$)	ADMI TTI NG (GROSS REVENUE)	CASHI ERI NG, A/R (GROSS REVENUE)	Reconci li ati on	OTHER ADMI N & GEN (ACCU M COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCH, RCVI NG, STORI NG	0				5.03
5.04	00570	ADMI TTI NG	0	647,996,887			5.04
5.05	00580	CASHI ERI NG, A/R	0	0	647,996,887		5.05
5.06	00590	OTHER ADMI N & GEN	0	0	0	-24,343,469	97,947,450
6.00	00600	MAI NTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	0	0	0	0	6,452,969
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	680,338
9.00	00900	HOUSEKEEPING	0	0	0	0	1,610,246
10.00	01000	DI ETARY	0	0	0	0	505,988
11.00	01100	CAFETERIA	0	0	0	0	1,059,253
12.00	01200	MAI NTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSI NG ADMI NISTRATION	0	0	0	0	2,177,651
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	701,940
15.00	01500	PHARMACY	0	0	0	0	2,054,502
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,673,038
17.00	01700	SOCI AL SERVI CE	0	0	0	0	903,798
19.00	01900	NONPHYSICI AN ANESTHETI STS	0	0	0	0	0
20.00	02000	NURSI NG SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0	763,482
22.00	02200	I&R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	886,673
23.00	02300	PARAMED ED PRGM-(SPECI FY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDI ATRI CS	0	58,277,743	58,277,743	0	11,307,378
31.00	03100	I NTENSIVE CARE UNI T	0	16,475,653	16,475,653	0	3,267,518
41.00	04100	SUBPROVI DER - I RF	0	8,579,606	8,579,606	0	2,548,117
43.00	04300	NURSERY	0	3,501,464	3,501,464	0	518,738
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATI NG ROOM	0	77,756,489	77,756,489	0	10,838,532
50.01	03330	ENDOSCOPY	0	20,386,637	20,386,637	0	1,420,171
51.00	05100	RECOVERY ROOM	0	8,807,722	8,807,722	0	788,667
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,462,816	4,462,816	0	1,625,187
53.00	05300	ANESTHESI OLOGY	0	30,385,729	30,385,729	0	2,359,474
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	10,036,166	10,036,166	0	1,215,805
54.01	03630	ULTRASOUND	0	4,781,053	4,781,053	0	413,028
54.02	03440	MAMMOGRAPHY	0	847,253	847,253	0	121,449
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	0	0
55.01	03480	ONCOLOGY	0	0	0	0	0
56.00	05600	RADI OI SOTOPE	0	3,904,965	3,904,965	0	393,950
57.00	05700	CT SCAN	0	28,568,970	28,568,970	0	684,175
58.00	05800	MRI	0	8,030,077	8,030,077	0	378,762
59.00	05900	CARDI AC CATHETERI ZATI ON	0	32,272,147	32,272,147	0	5,295,863
60.00	06000	LABORATORY	0	58,269,391	58,269,391	0	5,186,158
62.30	06250	BLOOD CLOTTI NG FOR HEMOPHI LI ACS	0	0	0	0	0
63.00	06300	BLOOD STORI NG, PROCESSI NG & TRANS.	0	2,122,599	2,122,599	0	470,022
65.00	06500	RESPI RATORY THERAPY	0	22,279,688	22,279,688	0	1,466,630
66.00	06600	PHYSI CAL THERAPY	0	7,172,855	7,172,855	0	890,196
67.00	06700	OCCUPATI ONAL THERAPY	0	5,555,045	5,555,045	0	799,492
68.00	06800	SPEECH PATHOLOGY	0	1,084,213	1,084,213	0	237,843
69.01	03140	CARDI OLOGY	0	9,799,241	9,799,241	0	688,403
71.00	07100	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	26,187,370	26,187,370	0	4,197,332
72.00	07200	I MPL. DEV. CHARGED TO PATI ENTS	0	35,381,576	35,381,576	0	5,528,882
73.00	07300	DRUGS CHARGED TO PATI ENTS	0	98,601,421	98,601,421	0	3,226,429
74.00	07400	RENAL DI ALYSI S	0	1,051,199	1,051,199	0	473,350
76.97	07697	CARDI AC REHABI LI TATI ON	0	1,285,736	1,285,736	0	491,891
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LI THOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	49,276,905	49,276,905	0	3,414,022
92.00	09200	OBSERVATI ON BEDS (NON-DI STI NCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVI CES	0	12,855,158	12,855,158	0	4,163,195
SPECIAL PURPOSE COST CENTERS							
113.00	11300	I NTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	647,996,887	647,996,887	-24,343,469	93,880,537
NONREIMBURSABLE COST CENTERS							
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	209,752

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description			PURCH, RCVI NG, S TORI NG (SUPPLI ES \$)	ADMI TTI NG (GROSS REVENUE)	CASHI ERI NG, A/R (GROSS REVENUE)	Reconci li ation	OTHER ADMI N & GEN (ACCUM COST)	
			5.03	5.04	5.05	5A.06	5.06	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,488,163	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	0	0	0	0	787,716	192.01
192.02	19202	REAL ESTATE	0	0	0	424,698	0	192.02
192.03	19203	FOUNDATION	0	0	0	0	141,632	192.03
192.04	19204	OUTREACH PROGRAMS	0	0	0	0	154,562	192.04
192.05	19205	UNASSIGNED	0	0	0	0	285,088	192.05
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)	0	800,674	57,274		24,343,469	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.001236	0.000088		0.248536	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	22,649	2,176		334,555	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000035	0.000003		0.003416	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL MEALS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600	0					6.00
7.00	00700	0	273,016				7.00
8.00	00800	0	973	672,925			8.00
9.00	00900	0	4,425	0	267,618		9.00
10.00	01000	0	11,498	0	11,498	98,666	10.00
11.00	01100	0	2,579	0	2,579	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	478	0	478	0	13.00
14.00	01400	0	13,215	53,885	13,215	0	14.00
15.00	01500	0	3,414	0	3,414	0	15.00
16.00	01600	0	8,306	0	8,306	0	16.00
17.00	01700	0	628	0	628	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	63,054	166,151	63,054	66,978	30.00
31.00	03100	0	10,158	35,556	10,158	11,338	31.00
41.00	04100	0	13,231	47,056	13,231	14,907	41.00
43.00	04300	0	3,835	1,625	3,835	5,443	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	27,548	95,258	27,548	0	50.00
50.01	03330	0	4,410	31,059	4,410	0	50.01
51.00	05100	0	2,390	11,642	2,390	0	51.00
52.00	05200	0	9,631	35,032	9,631	0	52.00
53.00	05300	0	404	0	404	0	53.00
54.00	05400	0	8,574	7,782	8,574	0	54.00
54.01	03630	0	2,275	2,987	2,275	0	54.01
54.02	03440	0	3,231	1,063	3,231	0	54.02
55.00	05500	0	0	0	0	0	55.00
55.01	03480	0	0	0	0	0	55.01
56.00	05600	0	1,245	3,408	1,245	0	56.00
57.00	05700	0	2,363	4,834	2,363	0	57.00
58.00	05800	0	1,581	2,083	1,581	0	58.00
59.00	05900	0	8,366	29,900	8,366	0	59.00
60.00	06000	0	11,656	0	11,656	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	6,133	0	6,133	0	65.00
66.00	06600	0	3,590	2,080	3,590	0	66.00
67.00	06700	0	2,328	2,031	2,328	0	67.00
68.00	06800	0	190	667	190	0	68.00
69.01	03140	0	2,568	5,655	2,568	0	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	425	1,258	425	0	74.00
76.97	07697	0	3,097	1,169	3,097	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	11,084	111,343	11,084	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	19,392	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		0	248,883	672,916	243,485	98,666	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,679	0	1,679	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL MEALS)	
		6.00	7.00	8.00	9.00	10.00	
192.00	19200	0	2,331	0	2,331	0	192.00
192.01	19201	0	741	0	741	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	8,255	9	8,255	0	192.04
192.05	19205	0	11,127	0	11,127	0	192.05
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)	0	8,056,764	878,139	2,141,033	1,063,041	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	29.510227	1.304958	8.000333	10.774137	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1,393,377	14,894	69,936	148,649	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	5.103646	0.022133	0.261328	1.506588	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		CAFETERIA (TOTAL EMLP FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (TOTAL REV EMP)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	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
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
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	87,010					11.00
12.00	01200	0	0				12.00
13.00	01300	2,948	0	71,678			13.00
14.00	01400	71	0	71	16,410,403		14.00
15.00	01500	1,898	0	1,898	23,755	3,896,802	15.00
16.00	01600	641	0	0	0	0	16.00
17.00	01700	1,137	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,064	0	25,064	142,357	8,757	30.00
31.00	03100	5,772	0	5,772	56,238	13,790	31.00
41.00	04100	3,785	0	3,785	18,742	804	41.00
43.00	04300	1,206	0	1,206	13,166	6	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,578	0	8,578	3,527,210	58,473	50.00
50.01	03330	1,974	0	1,974	214	33,806	50.01
51.00	05100	1,220	0	1,220	3,015	88	51.00
52.00	05200	2,822	0	2,822	0	12,051	52.00
53.00	05300	100	0	100	1,517	2,942	53.00
54.00	05400	2,123	0	2,123	1,197	10,282	54.00
54.01	03630	632	0	632	22,743	3,490	54.01
54.02	03440	83	0	83	0	1,770	54.02
55.00	05500	0	0	0	0	0	55.00
55.01	03480	0	0	0	0	0	55.01
56.00	05600	460	0	460	202,183	362	56.00
57.00	05700	937	0	937	60,851	27,875	57.00
58.00	05800	483	0	483	4,783	18,961	58.00
59.00	05900	2,896	0	2,896	2,098,284	28,661	59.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	466,244	0	63.00
65.00	06500	3,134	0	3,134	48	9	65.00
66.00	06600	0	0	0	2,773	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.01	03140	975	0	975	6,266	50,243	69.01
71.00	07100	0	0	0	4,156,424	209,381	71.00
72.00	07200	0	0	0	5,482,035	0	72.00
73.00	07300	0	0	0	0	3,318,303	73.00
74.00	07400	153	0	153	1,259	45	74.00
76.97	07697	626	0	626	3,592	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	6,686	0	6,686	11,290	59,902	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	8,925	0	0	90,547	16,191	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		85,329	0	71,678	16,396,733	3,876,192	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		CAFETERIA (TOTAL EMPL FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (TOTAL REV EMP)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	173	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,142	0	0	13,289	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	213	0	0	0	192.01
192.02	19202	REAL ESTATE	0	0	0	85	192.02
192.03	19203	FOUNDATION	20	0	0	0	192.03
192.04	19204	OUTREACH PROGRAMS	133	0	0	296	192.04
192.05	19205	UNASSIGNED	0	0	0	0	192.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,419,256	0	2,784,892	1,446,334	2,799,977
203.00		Unit cost multiplier (Wkst. B, Part I)	16.311412	0.000000	38.852814	0.088135	0.718532
204.00		Cost to be allocated (per Wkst. B, Part II)	40,628	0	357,785	357,816	76,672
205.00		Unit cost multiplier (Wkst. B, Part II)	0.466935	0.000000	4.991559	0.021804	0.019676

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONE						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00560 PURCH, RCVING, STORING						5.03
5.04 00570 ADMIN TTING						5.04
5.05 00580 CASHIERING, A/R						5.05
5.06 00590 OTHER ADMIN & GEN						5.06
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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	647,996,887					16.00
17.00 01700 SOCIAL SERVICE	0	10,000				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			10,000	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	58,277,743	6,371	0	0	8,426	30.00
31.00 03100 INTENSIVE CARE UNIT	16,475,653	1,080	0	0	451	31.00
41.00 04100 SUBPROVIDER - I&R	8,579,606	1,420	0	0	0	41.00
43.00 04300 NURSERY	3,501,464	529	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	77,756,489	0	0	0	0	50.00
50.01 03330 ENDOSCOPY	20,386,637	0	0	0	675	50.01
51.00 05100 RECOVERY ROOM	8,807,722	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4,462,816	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	30,385,729	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	10,036,166	0	0	0	0	54.00
54.01 03630 ULTRASOUND	4,781,053	0	0	0	0	54.01
54.02 03440 MAMMOGRAPHY	847,253	0	0	0	0	54.02
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 03480 ONCOLOGY	0	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	3,904,965	0	0	0	0	56.00
57.00 05700 CT SCAN	28,568,970	0	0	0	0	57.00
58.00 05800 MRI	8,030,077	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	32,272,147	0	0	0	0	59.00
60.00 06000 LABORATORY	58,269,391	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2,122,599	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	22,279,688	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	7,172,855	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	5,555,045	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1,084,213	0	0	0	0	68.00
69.01 03140 CARDIOLOGY	9,799,241	0	0	0	448	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,187,370	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	35,381,576	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	98,601,421	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	1,051,199	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	1,285,736	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	49,276,905	600	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	12,855,158	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)		
		16.00	17.00	19.00	20.00	21.00		
118.00	SUBTOTALS (SUM OF LINES 1-117)		647,996,887	10,000	0	0	10,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	COVENANT OUTPATIENT PHARMACY	0	0	0	0	0	192.01
192.02	19202	REAL ESTATE	0	0	0	0	0	192.02
192.03	19203	FOUNDATION	0	0	0	0	0	192.03
192.04	19204	OUTREACH PROGRAMS	0	0	0	0	0	192.04
192.05	19205	UNASSIGNED	0	0	0	0	0	192.05
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		2,410,867	1,170,526	0	0	953,235	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.003720	117.052600	0.000000	0.000000	95.323500	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		112,007	11,935	0	0	2,634	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000173	1.193500	0.000000	0.000000	0.263400	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00	23.00	
GENERAL SERVICE COST CENTERS			
1.00 00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01 00540 NONPATIENT TELEPHONE			5.01
5.02 00550 DATA PROCESSING			5.02
5.03 00560 PURCH, RCVING, STORING			5.03
5.04 00570 ADMIN TTING			5.04
5.05 00580 CASHIERING, A/R			5.05
5.06 00590 OTHER ADMIN & GEN			5.06
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
12.00 01200 MAINTENANCE OF PERSONNEL			12.00
13.00 01300 NURSING ADMINISTRATION			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY			14.00
15.00 01500 PHARMACY			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY			16.00
17.00 01700 SOCIAL SERVICE			17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS			19.00
20.00 02000 NURSING SCHOOL			20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	10,000		22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000 ADULTS & PEDIATRICS	8,426	0	30.00
31.00 03100 INTENSIVE CARE UNIT	451	0	31.00
41.00 04100 SUBPROVIDER - I&R	0	0	41.00
43.00 04300 NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
50.01 03330 ENDOSCOPY	675	0	50.01
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03630 ULTRASOUND	0	0	54.01
54.02 03440 MAMMOGRAPHY	0	0	54.02
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 03480 ONCOLOGY	0	0	55.01
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	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.01 03140 RADIOLOGY	448	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 09500 AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS			
113.00 11300 INTEREST EXPENSE			113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0113

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMETERED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00	23.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,000	0
	NONREIMBURSABLE COST CENTERS		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0
192.01	19201 COVENANT OUTPATIENT PHARMACY	0	0
192.02	19202 REAL ESTATE	0	0
192.03	19203 FOUNDATION	0	0
192.04	19204 OUTREACH PROGRAMS	0	0
192.05	19205 UNASSIGNED	0	0
200.00	Cross Foot Adjustments		
201.00	Negative Cost Centers		
202.00	Cost to be allocated (per Wkst. B, Part I)	1,107,043	0
203.00	Unit cost multiplier (Wkst. B, Part I)	110.704300	0.000000
204.00	Cost to be allocated (per Wkst. B, Part II)	3,029	0
205.00	Unit cost multiplier (Wkst. B, Part II)	0.302900	0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Dissallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	19,785,320	19,785,320	0	19,785,320	30.00
31.00	03100 INTENSIVE CARE UNIT	5,150,181	5,150,181	3,358	5,153,539	31.00
41.00	04100 SUBPROVIDER - I RF	4,308,892	4,308,892	0	4,308,892	41.00
43.00	04300 NURSERY	994,919	994,919	0	994,919	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	15,805,284	15,805,284	0	15,805,284	50.00
50.01	03330 ENDOSCOPY	2,188,129	2,188,129	0	2,188,129	50.01
51.00	05100 RECOVERY ROOM	1,189,915	1,189,915	0	1,189,915	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,617,018	2,617,018	0	2,617,018	52.00
53.00	05300 ANESTHESIOLOGY	3,081,841	3,081,841	0	3,081,841	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,011,689	2,011,689	0	2,011,689	54.00
54.01	03630 ULTRASOUND	662,077	662,077	0	662,077	54.01
54.02	03440 MAMMOGRAPHY	283,220	283,220	0	283,220	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	03480 ONCOLOGY	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	600,988	600,988	0	600,988	56.00
57.00	05700 CT SCAN	1,132,521	1,132,521	0	1,132,521	57.00
58.00	05800 MRI	605,483	605,483	0	605,483	58.00
59.00	05900 CARDIAC CATHETERIZATION	7,450,242	7,450,242	1,321	7,451,563	59.00
60.00	06000 LABORATORY	7,129,090	7,129,090	10,439	7,139,529	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	635,827	635,827	0	635,827	63.00
65.00	06500 RESPIRATORY THERAPY	2,316,967	2,316,967	2,833	2,319,800	65.00
66.00	06600 PHYSICAL THERAPY	1,275,746	1,275,746	0	1,275,746	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,108,835	1,108,835	0	1,108,835	67.00
68.00	06800 SPEECH PATHOLOGY	308,986	308,986	0	308,986	68.00
69.01	03140 RADIOLOGY	1,090,094	1,090,094	0	1,090,094	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,854,710	5,854,710	0	5,854,710	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,517,791	7,517,791	0	7,517,791	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,779,737	6,779,737	0	6,779,737	73.00
74.00	07400 RENAL DIALYSIS	621,072	621,072	0	621,072	74.00
76.97	07697 CARDIAC REHABILITATION	771,472	771,472	0	771,472	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	5,490,001	5,490,001	0	5,490,001	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,230,504	3,230,504	0	3,230,504	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5,436,219	5,436,219	0	5,436,219	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	117,434,770	117,434,770	17,951	117,452,721	200.00
201.00	Less Observation Beds	3,230,504	3,230,504		3,230,504	201.00
202.00	Total (see instructions)	114,204,266	114,204,266	17,951	114,222,217	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 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	50,178,825		50,178,825				30.00
31.00	03100	INTENSIVE CARE UNIT	16,475,653		16,475,653				31.00
41.00	04100	SUBPROVIDER - IRF	8,579,606		8,579,606				41.00
43.00	04300	NURSERY	3,501,464		3,501,464				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	32,550,047	45,206,442	77,756,489	0.203266	0.000000		50.00
50.01	03330	ENDOSCOPY	1,790,879	18,595,758	20,386,637	0.107332	0.000000		50.01
51.00	05100	RECOVERY ROOM	3,697,724	5,109,998	8,807,722	0.135099	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,217,946	244,870	4,462,816	0.586405	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	11,481,172	18,904,557	30,385,729	0.101424	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,749,104	6,287,062	10,036,166	0.200444	0.000000		54.00
54.01	03630	ULTRASOUND	2,093,491	2,687,562	4,781,053	0.138479	0.000000		54.01
54.02	03440	MAMMOGRAPHY	611	846,642	847,253	0.334280	0.000000		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
55.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000		55.01
56.00	05600	RADIOLOGY	1,239,968	2,664,997	3,904,965	0.153904	0.000000		56.00
57.00	05700	CT SCAN	8,363,712	20,205,258	28,568,970	0.039642	0.000000		57.00
58.00	05800	MRI	4,130,598	3,899,479	8,030,077	0.075402	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	12,276,751	19,995,396	32,272,147	0.230857	0.000000		59.00
60.00	06000	LABORATORY	26,673,541	31,595,850	58,269,391	0.122347	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,489,870	632,729	2,122,599	0.299551	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	20,367,391	1,912,297	22,279,688	0.103995	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	4,813,735	2,359,120	7,172,855	0.177857	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,248,628	1,306,417	5,555,045	0.199609	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	816,813	267,400	1,084,213	0.284986	0.000000		68.00
69.01	03140	CARDIOLOGY	4,717,683	5,081,558	9,799,241	0.111243	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,094,599	12,092,771	26,187,370	0.223570	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,463,604	13,917,972	35,381,576	0.212478	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,456,071	28,145,350	98,601,421	0.068759	0.000000		73.00
74.00	07400	RENAL DIALYSIS	980,082	71,117	1,051,199	0.590822	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	185,821	1,099,915	1,285,736	0.600024	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	10,353,098	38,923,807	49,276,905	0.111411	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,311,890	5,787,028	8,098,918	0.398881	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	12,855,158	12,855,158	0.422882	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	347,300,377	300,696,510	647,996,887				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	347,300,377	300,696,510	647,996,887				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	I NPATIENT ROUTINE SERVICE COST CENTERS	11.00		
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
	ANCI LLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.203266		50.00
50.01	03330 ENDOSCOPY	0.107332		50.01
51.00	05100 RECOVERY ROOM	0.135099		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.586405		52.00
53.00	05300 ANESTHESIOLOGY	0.101424		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.200444		54.00
54.01	03630 ULTRASOUND	0.138479		54.01
54.02	03440 MAMMOGRAPHY	0.334280		54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	03480 ONCOLOGY	0.000000		55.01
56.00	05600 RADIOISOTOPE	0.153904		56.00
57.00	05700 CT SCAN	0.039642		57.00
58.00	05800 MRI	0.075402		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.230898		59.00
60.00	06000 LABORATORY	0.122526		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.299551		63.00
65.00	06500 RESPIRATORY THERAPY	0.104122		65.00
66.00	06600 PHYSICAL THERAPY	0.177857		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.199609		67.00
68.00	06800 SPEECH PATHOLOGY	0.284986		68.00
69.01	03140 RADIOLOGY	0.111243		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.223570		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.212478		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.068759		73.00
74.00	07400 RENAL DIALYSIS	0.590822		74.00
76.97	07697 CARDIAC REHABILITATION	0.600024		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.111411		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.398881		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.422882		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0113

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 1:24 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	21,521,310	21,521,310	0	0	30.00	
31.00	03100 INTENSIVE CARE UNIT	5,243,100	5,243,100	0	0	31.00	
41.00	04100 SUBPROVIDER - I RF	4,308,892	4,308,892	0	0	41.00	
43.00	04300 NURSERY	994,919	994,919	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	15,805,284	15,805,284	0	0	50.00	
50.01	03330 ENDOSCOPY	2,327,197	2,327,197	0	0	50.01	
51.00	05100 RECOVERY ROOM	1,189,915	1,189,915	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,617,018	2,617,018	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	3,081,841	3,081,841	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,011,689	2,011,689	0	0	54.00	
54.01	03630 ULTRASOUND	662,077	662,077	0	0	54.01	
54.02	03440 MAMMOGRAPHY	283,220	283,220	0	0	54.02	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00	
55.01	03480 ONCOLOGY	0	0	0	0	55.01	
56.00	05600 RADIOISOTOPE	600,988	600,988	0	0	56.00	
57.00	05700 CT SCAN	1,132,521	1,132,521	0	0	57.00	
58.00	05800 MRI	605,483	605,483	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	7,450,242	7,450,242	0	0	59.00	
60.00	06000 LABORATORY	7,129,090	7,129,090	0	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	635,827	635,827	0	0	63.00	
65.00	06500 RESPIRATORY THERAPY	2,316,967	2,316,967	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	1,275,746	1,275,746	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	1,108,835	1,108,835	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	308,986	308,986	0	0	68.00	
69.01	03140 RADIOLOGY	1,182,395	1,182,395	0	0	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,854,710	5,854,710	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,517,791	7,517,791	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	6,779,737	6,779,737	0	0	73.00	
74.00	07400 RENAL DIALYSIS	621,072	621,072	0	0	74.00	
76.97	07697 CARDIAC REHABILITATION	771,472	771,472	0	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98	
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	5,490,001	5,490,001	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,513,978	3,513,978	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	5,436,219	5,436,219	0	0	95.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)	119,778,522	119,778,522	0	0	200.00	
201.00	Less Observation Beds	3,513,978	3,513,978	0	0	201.00	
202.00	Total (see instructions)	116,264,544	116,264,544	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,279,861		41,279,861			30.00
31.00	03100	INTENSIVE CARE UNIT	11,443,755		11,443,755			31.00
41.00	04100	SUBPROVIDER - I RF	7,936,904		7,936,904			41.00
43.00	04300	NURSERY	3,336,315		3,336,315			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,465,262	46,210,880	77,676,142	0.203477	0.000000	50.00
50.01	03330	ENDOSCOPY	1,803,501	15,814,797	17,618,298	0.132090	0.000000	50.01
51.00	05100	RECOVERY ROOM	4,116,744	5,618,486	9,735,230	0.122228	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,347,880	209,219	5,557,099	0.470932	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	10,072,789	18,010,782	28,083,571	0.109738	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,629,915	6,271,838	9,901,753	0.203165	0.000000	54.00
54.01	03630	ULTRASOUND	2,226,448	2,345,374	4,571,822	0.144817	0.000000	54.01
54.02	03440	MAMMOGRAPHY	976	767,780	768,756	0.368413	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	55.01
56.00	05600	RADIOLOGY	1,105,030	2,292,987	3,398,017	0.176864	0.000000	56.00
57.00	05700	CT SCAN	7,525,265	15,091,151	22,616,416	0.050075	0.000000	57.00
58.00	05800	MRI	4,650,756	4,144,981	8,795,737	0.068838	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,291,428	20,281,646	34,573,074	0.215493	0.000000	59.00
60.00	06000	LABORATORY	33,919,810	32,298,952	66,218,762	0.107660	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,473,354	578,020	2,051,374	0.309952	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	22,674,448	2,321,699	24,996,147	0.092693	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,427,349	1,509,989	5,937,338	0.214868	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,023,299	843,013	4,866,312	0.227859	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	860,677	225,158	1,085,835	0.284561	0.000000	68.00
69.01	03140	CARDIOLOGY	5,021,913	3,955,844	8,977,757	0.131703	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,791,491	11,550,861	24,342,352	0.240515	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,297,138	11,686,100	29,983,238	0.250733	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,474,523	23,537,700	69,012,223	0.098240	0.000000	73.00
74.00	07400	RENAL DIALYSIS	831,771	19,605	851,376	0.729492	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	187,532	1,040,585	1,228,117	0.628175	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10,222,522	32,813,100	43,035,622	0.127569	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,160,962	4,337,200	5,498,162	0.639119	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	10,877,292	10,877,292	0.499777	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	311,599,618	274,655,039	586,254,657			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	311,599,618	274,655,039	586,254,657			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	03330 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRASOUND	0.000000		54.01
54.02	03440 MAMMOGRAPHY	0.000000		54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	03480 ONCOLOGY	0.000000		55.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.01	03140 RADIOLOGY	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm	
			Title V	Hospital	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	21,521,310	21,521,310	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	5,243,100	5,243,100	0	0	31.00
41.00	04100 SUBPROVIDER - I RF	4,308,892	4,308,892	0	0	41.00
43.00	04300 NURSERY	994,919	994,919	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	15,805,284	15,805,284	0	0	50.00
50.01	03330 ENDOSCOPY	2,327,197	2,327,197	0	0	50.01
51.00	05100 RECOVERY ROOM	1,189,915	1,189,915	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,617,018	2,617,018	0	0	52.00
53.00	05300 ANESTHESIOLOGY	3,081,841	3,081,841	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,011,689	2,011,689	0	0	54.00
54.01	03630 ULTRASOUND	662,077	662,077	0	0	54.01
54.02	03440 MAMMOGRAPHY	283,220	283,220	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	03480 ONCOLOGY	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	600,988	600,988	0	0	56.00
57.00	05700 CT SCAN	1,132,521	1,132,521	0	0	57.00
58.00	05800 MRI	605,483	605,483	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	7,450,242	7,450,242	0	0	59.00
60.00	06000 LABORATORY	7,129,090	7,129,090	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	635,827	635,827	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	2,316,967	2,316,967	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,275,746	1,275,746	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,108,835	1,108,835	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	308,986	308,986	0	0	68.00
69.01	03140 RADIOLOGY	1,182,395	1,182,395	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,854,710	5,854,710	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,517,791	7,517,791	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,779,737	6,779,737	0	0	73.00
74.00	07400 RENAL DIALYSIS	621,072	621,072	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	771,472	771,472	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	5,490,001	5,490,001	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,513,978	3,513,978	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5,436,219	5,436,219	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	119,778,522	119,778,522	0	0	200.00
201.00	Less Observation Beds	3,513,978	3,513,978	0	0	201.00
202.00	Total (see instructions)	116,264,544	116,264,544	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm		
			Title V			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	41,279,861		41,279,861				30.00
31.00	03100	INTENSIVE CARE UNIT	11,443,755		11,443,755				31.00
41.00	04100	SUBPROVIDER - I RF	7,936,904		7,936,904				41.00
43.00	04300	NURSERY	3,336,315		3,336,315				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	31,465,262	46,210,880	77,676,142	0.203477	0.000000		50.00
50.01	03330	ENDOSCOPY	1,803,501	15,814,797	17,618,298	0.132090	0.000000		50.01
51.00	05100	RECOVERY ROOM	4,116,744	5,618,486	9,735,230	0.122228	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,347,880	209,219	5,557,099	0.470932	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	10,072,789	18,010,782	28,083,571	0.109738	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,629,915	6,271,838	9,901,753	0.203165	0.000000		54.00
54.01	03630	ULTRASOUND	2,226,448	2,345,374	4,571,822	0.144817	0.000000		54.01
54.02	03440	MAMMOGRAPHY	976	767,780	768,756	0.368413	0.000000		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
55.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000		55.01
56.00	05600	RADIOLOGY	1,105,030	2,292,987	3,398,017	0.176864	0.000000		56.00
57.00	05700	CT SCAN	7,525,265	15,091,151	22,616,416	0.050075	0.000000		57.00
58.00	05800	MRI	4,650,756	4,144,981	8,795,737	0.068838	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	14,291,428	20,281,646	34,573,074	0.215493	0.000000		59.00
60.00	06000	LABORATORY	33,919,810	32,298,952	66,218,762	0.107660	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,473,354	578,020	2,051,374	0.309952	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	22,674,448	2,321,699	24,996,147	0.092693	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	4,427,349	1,509,989	5,937,338	0.214868	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,023,299	843,013	4,866,312	0.227859	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	860,677	225,158	1,085,835	0.284561	0.000000		68.00
69.01	03140	CARDIOLOGY	5,021,913	3,955,844	8,977,757	0.131703	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,791,491	11,550,861	24,342,352	0.240515	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,297,138	11,686,100	29,983,238	0.250733	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,474,523	23,537,700	69,012,223	0.098240	0.000000		73.00
74.00	07400	RENAL DIALYSIS	831,771	19,605	851,376	0.729492	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	187,532	1,040,585	1,228,117	0.628175	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	10,222,522	32,813,100	43,035,622	0.127569	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,160,962	4,337,200	5,498,162	0.639119	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	10,877,292	10,877,292	0.499777	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	311,599,618	274,655,039	586,254,657				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	311,599,618	274,655,039	586,254,657				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 1:24 pm
Cost Center Description			PPS Inpatient Ratio	Title V	Hospital Cost
			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	0.000000		50.00
50.01	03330	ENDOSCOPY	0.000000		50.01
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRASOUND	0.000000		54.01
54.02	03440	MAMMOGRAPHY	0.000000		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	03480	ONCOLOGY	0.000000		55.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.01	03140	CARDIOLOGY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/24/2017 1:24 pm
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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)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,224,483	0	1,224,483	23,708	51.65	30.00	
31.00	INTENSIVE CARE UNIT	286,251		286,251	3,358	85.24	31.00	
41.00	SUBPROVIDER - IRF	245,966	0	245,966	4,415	55.71	41.00	
43.00	NURSERY	73,307		73,307	1,612	45.48	43.00	
200.00	Total (lines 30-199)	1,830,007		1,830,007	33,093		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	7,160	369,814					30.00
31.00	INTENSIVE CARE UNIT	1,548	131,952					31.00
41.00	SUBPROVIDER - IRF	2,657	148,021					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	11,365	649,787					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,712,076	77,756,489	0.022018	11,615,071	255,741	50.00
50.01	03330 ENDOSCOPY	111,854	20,386,637	0.005487	798,311	4,380	50.01
51.00	05100 RECOVERY ROOM	114,651	8,807,722	0.013017	1,299,204	16,912	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	335,562	4,462,816	0.075191	5,475	412	52.00
53.00	05300 ANESTHESIOLOGY	34,963	30,385,729	0.001151	3,724,813	4,287	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	227,227	10,036,166	0.022641	1,655,397	37,480	54.00
54.01	03630 ULTRASOUND	46,573	4,781,053	0.009741	904,865	8,814	54.01
54.02	03440 MAMMOGRAPHY	60,437	847,253	0.071333	611	44	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	03480 ONCOLOGY	0	0	0.000000	0	0	55.01
56.00	05600 RADIOISOTOPE	31,202	3,904,965	0.007990	576,269	4,604	56.00
57.00	05700 CT SCAN	50,396	28,568,970	0.001764	3,876,061	6,837	57.00
58.00	05800 MRI	154,939	8,030,077	0.019295	1,542,615	29,765	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,402,356	32,272,147	0.043454	5,009,353	217,676	59.00
60.00	06000 LABORATORY	390,336	58,269,391	0.006699	10,914,587	73,117	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12,219	2,122,599	0.005757	732,023	4,214	63.00
65.00	06500 RESPIRATORY THERAPY	143,608	22,279,688	0.006446	8,504,386	54,819	65.00
66.00	06600 PHYSICAL THERAPY	51,912	7,172,855	0.007237	884,793	6,403	66.00
67.00	06700 OCCUPATIONAL THERAPY	35,241	5,555,045	0.006344	750,759	4,763	67.00
68.00	06800 SPEECH PATHOLOGY	4,110	1,084,213	0.003791	116,089	440	68.00
69.01	03140 RADIOLOGY	112,305	9,799,241	0.011461	2,187,570	25,072	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	114,611	26,187,370	0.004377	6,096,508	26,684	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	145,887	35,381,576	0.004123	7,739,555	31,910	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,217	98,601,421	0.000986	26,419,438	26,050	73.00
74.00	07400 RENAL DIALYSIS	8,666	1,051,199	0.008244	632,364	5,213	74.00
76.97	07697 CARDIAC REHABILITATION	60,862	1,285,736	0.047336	56,912	2,694	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	326,766	49,276,905	0.006631	4,175,947	27,691	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	199,929	8,098,918	0.024686	1,066,710	26,333	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	5,985,905	556,406,181		101,285,686	902,355	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	PPS	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			6.00	7.00	8.00	9.00		
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,708	0.00	7,160	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,358	0.00	1,548	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	4,415	0.00	2,657	0	0	41.00
43.00	04300	NURSERY	1,612	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	33,093		11,365	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
50.01	03330	ENDOSCOPY	0	0	0	0	0	50.01	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	03630	ULTRASOUND	0	0	0	0	0	54.01	
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
55.01	03480	ONCOLOGY	0	0	0	0	0	55.01	
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	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.01	03140	CARDIOLOGY	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRI PSY	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
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: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	77,756,489	0.000000	0.000000	11,615,071	50.00
50.01	03330	ENDOSCOPY	0	20,386,637	0.000000	0.000000	798,311	50.01
51.00	05100	RECOVERY ROOM	0	8,807,722	0.000000	0.000000	1,299,204	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,462,816	0.000000	0.000000	5,475	52.00
53.00	05300	ANESTHESIOLOGY	0	30,385,729	0.000000	0.000000	3,724,813	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,036,166	0.000000	0.000000	1,655,397	54.00
54.01	03630	ULTRASOUND	0	4,781,053	0.000000	0.000000	904,865	54.01
54.02	03440	MAMMOGRAPHY	0	847,253	0.000000	0.000000	611	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	03480	ONCOLOGY	0	0	0.000000	0.000000	0	55.01
56.00	05600	RADIOISOTOPE	0	3,904,965	0.000000	0.000000	576,269	56.00
57.00	05700	CT SCAN	0	28,568,970	0.000000	0.000000	3,876,061	57.00
58.00	05800	MRI	0	8,030,077	0.000000	0.000000	1,542,615	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	32,272,147	0.000000	0.000000	5,009,353	59.00
60.00	06000	LABORATORY	0	58,269,391	0.000000	0.000000	10,914,587	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,122,599	0.000000	0.000000	732,023	63.00
65.00	06500	RESPIRATORY THERAPY	0	22,279,688	0.000000	0.000000	8,504,386	65.00
66.00	06600	PHYSICAL THERAPY	0	7,172,855	0.000000	0.000000	884,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,555,045	0.000000	0.000000	750,759	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,084,213	0.000000	0.000000	116,089	68.00
69.01	03140	CARDIOLOGY	0	9,799,241	0.000000	0.000000	2,187,570	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,187,370	0.000000	0.000000	6,096,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,381,576	0.000000	0.000000	7,739,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	98,601,421	0.000000	0.000000	26,419,438	73.00
74.00	07400	RENAL DIALYSIS	0	1,051,199	0.000000	0.000000	632,364	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,285,736	0.000000	0.000000	56,912	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	49,276,905	0.000000	0.000000	4,175,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,098,918	0.000000	0.000000	1,066,710	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	556,406,181			101,285,686	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	8,955,826	0		50.00
50.01	03330 ENDOSCOPY	0	3,716,755	0		50.01
51.00	05100 RECOVERY ROOM	0	867,360	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	3,680,732	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,297,825	0		54.00
54.01	03630 ULTRASOUND	0	578,084	0		54.01
54.02	03440 MAMMOGRAPHY	0	37,646	0		54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	03480 ONCOLOGY	0	0	0		55.01
56.00	05600 RADIOISOTOPE	0	805,500	0		56.00
57.00	05700 CT SCAN	0	4,325,451	0		57.00
58.00	05800 MRI	0	656,490	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,748,344	0		59.00
60.00	06000 LABORATORY	0	7,126,238	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	310,127	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	431,743	0		65.00
66.00	06600 PHYSICAL THERAPY	0	67,598	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	54,268	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	5,269	0		68.00
69.01	03140 RADIOLOGY	0	1,909,176	0		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,837,592	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,336,306	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,639,074	0		73.00
74.00	07400 RENAL DIALYSIS	0	58,365	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	325,238	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	6,546,648	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,992,123	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	64,309,778	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 1:24 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	0.203266	8,955,826	0	472	1,820,415
50.01 03330 ENDOSCOPY	0.107332	3,716,755	0	0	398,927
51.00 05100 RECOVERY ROOM	0.135099	867,360	0	0	117,179
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.586405	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.101424	3,680,732	0	0	373,315
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.200444	1,297,825	0	0	260,141
54.01 03630 ULTRASOUND	0.138479	578,084	0	0	80,052
54.02 03440 MAMMOGRAPHY	0.334280	37,646	0	0	12,584
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
55.01 03480 ONCOLOGY	0.000000	0	0	0	0
56.00 05600 RADIOISOTOPE	0.153904	805,500	0	139	123,970
57.00 05700 CT SCAN	0.039642	4,325,451	0	0	171,470
58.00 05800 MRI	0.075402	656,490	0	244	49,501
59.00 05900 CARDIAC CATHETERIZATION	0.230857	6,748,344	0	0	1,557,902
60.00 06000 LABORATORY	0.122347	7,126,238	0	0	871,874
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.299551	310,127	0	0	92,899
65.00 06500 RESPIRATORY THERAPY	0.103995	431,743	0	0	44,899
66.00 06600 PHYSICAL THERAPY	0.177857	67,598	0	0	12,023
67.00 06700 OCCUPATIONAL THERAPY	0.199609	54,268	0	0	10,832
68.00 06800 SPEECH PATHOLOGY	0.284986	5,269	0	0	1,502
69.01 03140 RADIOLOGY	0.111243	1,909,176	0	697	212,382
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.223570	2,837,592	0	0	634,400
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.212478	4,336,306	0	0	921,370
73.00 07300 DRUGS CHARGED TO PATIENTS	0.068759	6,639,074	0	61,469	456,496
74.00 07400 RENAL DIALYSIS	0.590822	58,365	0	0	34,483
76.97 07697 CARDIAC REHABILITATION	0.600024	325,238	0	0	195,151
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0.111411	6,546,648	0	0	729,369
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.398881	1,992,123	0	0	794,620
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.422882		0		
200.00	Subtotal (see instructions)	64,309,778	0	63,021	9,977,756
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	
202.00	Net Charges (line 200 +/- line 201)	64,309,778	0	63,021	9,977,756

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 1:24 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	96		50.00
50.01 03330 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRASOUND	0	0		54.01
54.02 03440 MAMMOGRAPHY	0	0		54.02
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 03480 ONCOLOGY	0	0		55.01
56.00 05600 RADIOISOTOPE	0	21		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	18		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.01 03140 RADIOLOGY	0	78		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,227		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	4,440		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,440		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/24/2017 1:24 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	1,712,076	77,756,489	0.022018	23,505	518	50.00
50.01	03330	ENDOSCOPY	111,854	20,386,637	0.005487	10,854	60	50.01
51.00	05100	RECOVERY ROOM	114,651	8,807,722	0.013017	7,018	91	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	335,562	4,462,816	0.075191	49	4	52.00
53.00	05300	ANESTHESIOLOGY	34,963	30,385,729	0.001151	12,690	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,227	10,036,166	0.022641	91,852	2,080	54.00
54.01	03630	ULTRASOUND	46,573	4,781,053	0.009741	68,049	663	54.01
54.02	03440	MAMMOGRAPHY	60,437	847,253	0.071333	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0.000000	0	0	55.01
56.00	05600	RADIOISOTOPE	31,202	3,904,965	0.007990	18	0	56.00
57.00	05700	CT SCAN	50,396	28,568,970	0.001764	139,948	247	57.00
58.00	05800	MRI	154,939	8,030,077	0.019295	114,081	2,201	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,402,356	32,272,147	0.043454	35,694	1,551	59.00
60.00	06000	LABORATORY	390,336	58,269,391	0.006699	779,022	5,219	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,219	2,122,599	0.005757	10,917	63	63.00
65.00	06500	RESPIRATORY THERAPY	143,608	22,279,688	0.006446	735,111	4,739	65.00
66.00	06600	PHYSICAL THERAPY	51,912	7,172,855	0.007237	1,816,070	13,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,241	5,555,045	0.006344	1,657,486	10,515	67.00
68.00	06800	SPEECH PATHOLOGY	4,110	1,084,213	0.003791	324,291	1,229	68.00
69.01	03140	CARDIOLOGY	112,305	9,799,241	0.011461	57,404	658	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,611	26,187,370	0.004377	473,854	2,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,887	35,381,576	0.004123	1,703	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,217	98,601,421	0.000986	2,064,964	2,036	73.00
74.00	07400	RENAL DIALYSIS	8,666	1,051,199	0.008244	70,583	582	74.00
76.97	07697	CARDIAC REHABILITATION	60,862	1,285,736	0.047336	6,898	327	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	326,766	49,276,905	0.006631	64,871	430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,098,918	0.000000	40,949	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,785,976	556,406,181		8,607,881	48,452	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 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
50.01	03330 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630 ULTRASOUND	0	0	0	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	03480 ONCOLOGY	0	0	0	0	0	55.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.01	03140 CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
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: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 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	77,756,489	0.000000	0.000000	23,505	50.00
50.01	03330 ENDOSCOPY	0	20,386,637	0.000000	0.000000	10,854	50.01
51.00	05100 RECOVERY ROOM	0	8,807,722	0.000000	0.000000	7,018	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4,462,816	0.000000	0.000000	49	52.00
53.00	05300 ANESTHESIOLOGY	0	30,385,729	0.000000	0.000000	12,690	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	10,036,166	0.000000	0.000000	91,852	54.00
54.01	03630 ULTRASOUND	0	4,781,053	0.000000	0.000000	68,049	54.01
54.02	03440 MAMMOGRAPHY	0	847,253	0.000000	0.000000	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	03480 ONCOLOGY	0	0	0.000000	0.000000	0	55.01
56.00	05600 RADIOISOTOPE	0	3,904,965	0.000000	0.000000	18	56.00
57.00	05700 CT SCAN	0	28,568,970	0.000000	0.000000	139,948	57.00
58.00	05800 MRI	0	8,030,077	0.000000	0.000000	114,081	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	32,272,147	0.000000	0.000000	35,694	59.00
60.00	06000 LABORATORY	0	58,269,391	0.000000	0.000000	779,022	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2,122,599	0.000000	0.000000	10,917	63.00
65.00	06500 RESPIRATORY THERAPY	0	22,279,688	0.000000	0.000000	735,111	65.00
66.00	06600 PHYSICAL THERAPY	0	7,172,855	0.000000	0.000000	1,816,070	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	5,555,045	0.000000	0.000000	1,657,486	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,084,213	0.000000	0.000000	324,291	68.00
69.01	03140 RADIOLOGY	0	9,799,241	0.000000	0.000000	57,404	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,187,370	0.000000	0.000000	473,854	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	35,381,576	0.000000	0.000000	1,703	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	98,601,421	0.000000	0.000000	2,064,964	73.00
74.00	07400 RENAL DIALYSIS	0	1,051,199	0.000000	0.000000	70,583	74.00
76.97	07697 CARDIAC REHABILITATION	0	1,285,736	0.000000	0.000000	6,898	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	49,276,905	0.000000	0.000000	64,871	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8,098,918	0.000000	0.000000	40,949	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	556,406,181			8,607,881	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 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
50.01	03330 ENDOSCOPY	0	0	0	50.01
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
54.01	03630 ULTRASOUND	0	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01	03480 ONCOLOGY	0	0	0	55.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.01	03140 RADIOLOGY	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	615	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	615	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 1:24 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.203266	0	0	2	0	50.00	
50.01 03330 ENDOSCOPY	0.107332	0	0	0	0	50.01	
51.00 05100 RECOVERY ROOM	0.135099	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.586405	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.101424	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.200444	0	0	0	0	54.00	
54.01 03630 ULTRASOUND	0.138479	0	0	0	0	54.01	
54.02 03440 MAMMOGRAPHY	0.334280	0	0	0	0	54.02	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
55.01 03480 ONCOLOGY	0.000000	0	0	0	0	55.01	
56.00 05600 RADIOISOTOPE	0.153904	0	0	1	0	56.00	
57.00 05700 CT SCAN	0.039642	0	0	0	0	57.00	
58.00 05800 MRI	0.075402	0	0	3	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0.230857	0	0	0	0	59.00	
60.00 06000 LABORATORY	0.122347	0	0	0	0	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.299551	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	0.103995	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.177857	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.199609	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.284986	0	0	0	0	68.00	
69.01 03140 RADIOLOGY	0.111243	0	0	7	0	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.223570	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.212478	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.068759	615	0	1,460	42	73.00	
74.00 07400 RENAL DIALYSIS	0.590822	0	0	0	0	74.00	
76.97 07697 CARDIAC REHABILITATION	0.600024	0	0	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0.111411	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.398881	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0.422882	0	0	0	0	95.00	
200.00 Subtotal (see instructions)		615	0	1,473	42	200.00	
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00 Net Charges (line 200 +/- line 201)		615	0	1,473	42	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 1:24 pm
		Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
50.01 03330 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRASOUND	0	0		54.01
54.02 03440 MAMMOGRAPHY	0	0		54.02
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 03480 ONCOLOGY	0	0		55.01
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	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.01 03140 CARDIOLOGY	0	1		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	100		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	101		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	101		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/24/2017 1:24 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	Hospital Cost Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,224,483	0	1,224,483	23,708	51.65	30.00
31.00	INTENSIVE CARE UNIT	286,251	0	286,251	3,358	85.24	31.00
41.00	SUBPROVIDER - IRF	245,966	0	245,966	4,415	55.71	41.00
43.00	NURSERY	73,307		73,307	1,612	45.48	43.00
200.00	Total (Lines 30-199)	1,830,007		1,830,007	33,093		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	1,595	82,382				
31.00	INTENSIVE CARE UNIT	62	5,285				
41.00	SUBPROVIDER - IRF	166	9,248				
43.00	NURSERY	408	18,556				
200.00	Total (Lines 30-199)	2,231	115,471				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Title XIX			Hospital	Cost
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,712,076	77,676,142	0.022041	0	0 50.00
50.01	03330 ENDOSCOPY	111,854	17,618,298	0.006349	0	0 50.01
51.00	05100 RECOVERY ROOM	114,651	9,735,230	0.011777	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	335,562	5,557,099	0.060384	0	0 52.00
53.00	05300 ANESTHESIOLOGY	34,963	28,083,571	0.001245	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	227,227	9,901,753	0.022948	0	0 54.00
54.01	03630 ULTRASOUND	46,573	4,571,822	0.010187	0	0 54.01
54.02	03440 MAMMOGRAPHY	60,437	768,756	0.078617	0	0 54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0 55.00
55.01	03480 ONCOLOGY	0	0	0.000000	0	0 55.01
56.00	05600 RADIOISOTOPE	31,202	3,398,017	0.009182	0	0 56.00
57.00	05700 CT SCAN	50,396	22,616,416	0.002228	0	0 57.00
58.00	05800 MRI	154,939	8,795,737	0.017615	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	1,402,356	34,573,074	0.040562	0	0 59.00
60.00	06000 LABORATORY	390,336	66,218,762	0.005895	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12,219	2,051,374	0.005956	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	143,608	24,996,147	0.005745	0	0 65.00
66.00	06600 PHYSICAL THERAPY	51,912	5,937,338	0.008743	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	35,241	4,866,312	0.007242	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	4,110	1,085,835	0.003785	0	0 68.00
69.01	03140 RADIOLOGY	112,305	8,977,757	0.012509	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	114,611	24,342,352	0.004708	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	145,887	29,983,238	0.004866	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,217	69,012,223	0.001409	0	0 73.00
74.00	07400 RENAL DIALYSIS	8,666	851,376	0.010179	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	60,862	1,228,117	0.049557	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	326,766	43,035,622	0.007593	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	199,931	5,498,162	0.036363	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	5,985,907	511,380,530		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			Title XIX		Hospital		Cost	
			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	23,708	0.00	1,595	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,358	0.00	62	0		31.00
41.00	04100	SUBPROVIDER - IRF	4,415	0.00	166	0		41.00
43.00	04300	NURSERY	1,612	0.00	408	0		43.00
200.00		Total (lines 30-199)	33,093		2,231	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		Title XIX				Hospital	Cost
		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
50.01	03330	ENDOSCOPY	0	0	0	0	50.01
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
54.01	03630	ULTRASOUND	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.01	03140	CARDIOLOGY	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Inpatient Program Charges	Cost	
			Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)				
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	77,676,142	0.000000	0.000000		0	50.00
50.01	03330	ENDOSCOPY	0	17,618,298	0.000000	0.000000		0	50.01
51.00	05100	RECOVERY ROOM	0	9,735,230	0.000000	0.000000		0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,557,099	0.000000	0.000000		0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,083,571	0.000000	0.000000		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,901,753	0.000000	0.000000		0	54.00
54.01	03630	ULTRASOUND	0	4,571,822	0.000000	0.000000		0	54.01
54.02	03440	MAMMOGRAPHY	0	768,756	0.000000	0.000000		0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000		0	55.00
55.01	03480	ONCOLOGY	0	0	0.000000	0.000000		0	55.01
56.00	05600	RADIOISOTOPE	0	3,398,017	0.000000	0.000000		0	56.00
57.00	05700	CT SCAN	0	22,616,416	0.000000	0.000000		0	57.00
58.00	05800	MRI	0	8,795,737	0.000000	0.000000		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	34,573,074	0.000000	0.000000		0	59.00
60.00	06000	LABORATORY	0	66,218,762	0.000000	0.000000		0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000		0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,051,374	0.000000	0.000000		0	63.00
65.00	06500	RESPIRATORY THERAPY	0	24,996,147	0.000000	0.000000		0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,937,338	0.000000	0.000000		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,866,312	0.000000	0.000000		0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,085,835	0.000000	0.000000		0	68.00
69.01	03140	CARDIOLOGY	0	8,977,757	0.000000	0.000000		0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,342,352	0.000000	0.000000		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,983,238	0.000000	0.000000		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,012,223	0.000000	0.000000		0	73.00
74.00	07400	RENAL DIALYSIS	0	851,376	0.000000	0.000000		0	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,228,117	0.000000	0.000000		0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000		0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000		0	76.99
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	43,035,622	0.000000	0.000000		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,498,162	0.000000	0.000000		0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	511,380,530				0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
50.01	03330 ENDOSCOPY	0	0	0		50.01
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
54.01	03630 ULTRASOUND	0	0	0		54.01
54.02	03440 MAMMOGRAPHY	0	0	0		54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	03480 ONCOLOGY	0	0	0		55.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.01	03140 RADIOLOGY	0	0	0		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Title V			Hospital	Cost	
		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	1,224,483	0	1,224,483	23,708	51.65	30.00
31.00	INTENSIVE CARE UNIT	286,251	0	286,251	3,358	85.24	31.00
41.00	SUBPROVIDER - IRF	245,966	0	245,966	4,415	55.71	41.00
43.00	NURSERY	73,307		73,307	1,612	45.48	43.00
200.00	Total (lines 30-199)	1,830,007		1,830,007	33,093		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	0	0				
31.00	INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Title V			Hospital	Cost
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,712,076	77,676,142	0.022041	0	0 50.00
50.01	03330 ENDOSCOPY	111,854	17,618,298	0.006349	0	0 50.01
51.00	05100 RECOVERY ROOM	114,651	9,735,230	0.011777	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	335,562	5,557,099	0.060384	0	0 52.00
53.00	05300 ANESTHESIOLOGY	34,963	28,083,571	0.001245	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	227,227	9,901,753	0.022948	0	0 54.00
54.01	03630 ULTRASOUND	46,573	4,571,822	0.010187	0	0 54.01
54.02	03440 MAMMOGRAPHY	60,437	768,756	0.078617	0	0 54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0 55.00
55.01	03480 ONCOLOGY	0	0	0.000000	0	0 55.01
56.00	05600 RADIOISOTOPE	31,202	3,398,017	0.009182	0	0 56.00
57.00	05700 CT SCAN	50,396	22,616,416	0.002228	0	0 57.00
58.00	05800 MRI	154,939	8,795,737	0.017615	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	1,402,356	34,573,074	0.040562	0	0 59.00
60.00	06000 LABORATORY	390,336	66,218,762	0.005895	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12,219	2,051,374	0.005956	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	143,608	24,996,147	0.005745	0	0 65.00
66.00	06600 PHYSICAL THERAPY	51,912	5,937,338	0.008743	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	35,241	4,866,312	0.007242	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	4,110	1,085,835	0.003785	0	0 68.00
69.01	03140 RADIOLOGY	112,305	8,977,757	0.012509	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	114,611	24,342,352	0.004708	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	145,887	29,983,238	0.004866	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,217	69,012,223	0.001409	0	0 73.00
74.00	07400 RENAL DIALYSIS	8,666	851,376	0.010179	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	60,862	1,228,117	0.049557	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	326,766	43,035,622	0.007593	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	199,931	5,498,162	0.036363	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	5,985,907	511,380,530		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			Title V		Hospital		Cost	
			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	23,708	0.00	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,358	0.00	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	4,415	0.00	0	0	0	41.00
43.00	04300	NURSERY	1,612	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	33,093		0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0113

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		Title V				Hospital	Cost
		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
50.01	03330	ENDOSCOPY	0	0	0	0	50.01
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
54.01	03630	ULTRASOUND	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	03480	ONCOLOGY	0	0	0	0	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.01	03140	CARDIOLOGY	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description	Title V			Hospital		Inpatient Program Charges	Cost	
	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)				
	6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	77,676,142	0.000000	0.000000	0	50.00
50.01	03330	ENDOSCOPY	0	17,618,298	0.000000	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0	9,735,230	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,557,099	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,083,571	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,901,753	0.000000	0.000000	0	54.00
54.01	03630	ULTRASOUND	0	4,571,822	0.000000	0.000000	0	54.01
54.02	03440	MAMMOGRAPHY	0	768,756	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	03480	ONCOLOGY	0	0	0.000000	0.000000	0	55.01
56.00	05600	RADIOISOTOPE	0	3,398,017	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	22,616,416	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	8,795,737	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	34,573,074	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	66,218,762	0.000000	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,051,374	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	24,996,147	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,937,338	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,866,312	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,085,835	0.000000	0.000000	0	68.00
69.01	03140	CARDIOLOGY	0	8,977,757	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,342,352	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,983,238	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,012,223	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	851,376	0.000000	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,228,117	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	43,035,622	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,498,162	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	511,380,530			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 1:24 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
50.01	03330 ENDOSCOPY	0	0	0		50.01
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
54.01	03630 ULTRASOUND	0	0	0		54.01
54.02	03440 MAMMOGRAPHY	0	0	0		54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	03480 ONCOLOGY	0	0	0		55.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.01	03140 RADIOLOGY	0	0	0		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/24/2017 1:24 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)		23,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,708	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)		19,837	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)		7,160	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)		19,785,320	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)		19,785,320	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)		19,785,320	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)		834.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,975,306	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)		5,975,306	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,153,539	3,358	1,534.70	2,375,716	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)				14,124,093	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				22,475,115	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)				501,766	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				902,355	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,404,121	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				21,070,994	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)				3,871	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				834.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				3,230,504	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 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	1,224,483	19,785,320	0.061888	3,230,504	199,929	90.00
91.00	Nursing School cost	0	19,785,320	0.000000	3,230,504	0	91.00
92.00	Allied health cost	0	19,785,320	0.000000	3,230,504	0	92.00
93.00	All other Medical Education	0	19,785,320	0.000000	3,230,504	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 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)		4,415	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,415	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)		4,415	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,657	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)		4,308,892	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)		4,308,892	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)		4,308,892	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)		975.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,593,152	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)		2,593,152	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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)					1,304,040	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,897,192	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)					148,021	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					48,452	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					196,473	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,700,719	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: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 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	245,966	4,308,892	0.057083	0	0	90.00
91.00	Nursing School cost	0	4,308,892	0.000000	0	0	91.00
92.00	Allied health cost	0	4,308,892	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,308,892	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/24/2017 1:24 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		23,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,708	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)		19,837	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)		1,595	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)		1,612	15.00
16.00	Nursery days (title V or XIX only)		408	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)		21,521,310	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)		21,521,310	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)		21,521,310	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)		907.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,447,893	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,447,893	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm		
Cost Center Description			Title XIX		Hospital	Cost	
	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)	994,919	1,612	617.20	408	251,818	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,243,100	3,358	1,561.38	62	96,806	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)					1,796,517	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,871	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					907.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,513,978	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 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	1,224,483	21,521,310	0.056896	3,513,978	199,931	90.00
91.00	Nursing School cost	0	21,521,310	0.000000	3,513,978	0	91.00
92.00	Allied health cost	0	21,521,310	0.000000	3,513,978	0	92.00
93.00	All other Medical Education	0	21,521,310	0.000000	3,513,978	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm
		Title XIX	Subprovider - IRF	Cost
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)			4,415 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,415 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)			4,415 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			166 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)			1,612 15.00
16.00	Nursery days (title V or XIX only)			408 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)			4,308,892 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)			4,308,892 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)			4,308,892 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)			975.97 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			162,011 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)			162,011 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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)					162,011	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					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: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm	
		Title XIX		Subprovider - IRF		Cost	
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	245,966	4,308,892	0.057083	0	0	90.00
91.00	Nursing School cost	0	4,308,892	0.000000	0	0	91.00
92.00	Allied health cost	0	4,308,892	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,308,892	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Date/Time Prepared: 5/24/2017 1:24 pm		
Cost Center Description		Title V	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		23,708	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,708	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)		19,837	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)		0	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)		1,612	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)		21,521,310	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)		21,521,310	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)		21,521,310	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)		907.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1	
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)	994,919	1,612	617.20	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,243,100	3,358	1,561.38	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)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,871	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					907.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,513,978	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 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	1,224,483	21,521,310	0.056896	3,513,978	199,931	90.00
91.00	Nursing School cost	0	21,521,310	0.000000	3,513,978	0	91.00
92.00	Allied health cost	0	21,521,310	0.000000	3,513,978	0	92.00
93.00	All other Medical Education	0	21,521,310	0.000000	3,513,978	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm
		Title V	Subprovider - IRF	Cost
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)			4,415 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,415 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)			4,415 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			0 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)			1,612 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)			4,308,892 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)			4,308,892 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)			4,308,892 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)			975.97 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0 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)			0 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					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: 14-0113 Component CCN: 14-T113		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 1:24 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	245,966	4,308,892	0.057083	0	0	90.00
91.00	Nursing School cost	0	4,308,892	0.000000	0	0	91.00
92.00	Allied health cost	0	4,308,892	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,308,892	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/24/2017 1:24 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		18,561,231	30.00
31.00	03100	INTENSIVE CARE UNIT		6,833,980	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	0.203266	11,615,071	50.00
50.01	03330	ENDOSCOPY	0.107332	798,311	50.01
51.00	05100	RECOVERY ROOM	0.135099	1,299,204	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.586405	5,475	52.00
53.00	05300	ANESTHESIOLOGY	0.101424	3,724,813	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200444	1,655,397	54.00
54.01	03630	ULTRASOUND	0.138479	904,865	54.01
54.02	03440	MAMMOGRAPHY	0.334280	611	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
55.01	03480	ONCOLOGY	0.000000	0	55.01
56.00	05600	RADIOISOTOPE	0.153904	576,269	56.00
57.00	05700	CT SCAN	0.039642	3,876,061	57.00
58.00	05800	MRI	0.075402	1,542,615	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.230898	5,009,353	59.00
60.00	06000	LABORATORY	0.122526	10,914,587	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.299551	732,023	63.00
65.00	06500	RESPIRATORY THERAPY	0.104122	8,504,386	65.00
66.00	06600	PHYSICAL THERAPY	0.177857	884,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.199609	750,759	67.00
68.00	06800	SPEECH PATHOLOGY	0.284986	116,089	68.00
69.01	03140	CARDIOLOGY	0.111243	2,187,570	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.223570	6,096,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.212478	7,739,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.068759	26,419,438	73.00
74.00	07400	RENAL DIALYSIS	0.590822	632,364	74.00
76.97	07697	CARDIAC REHABILITATION	0.600024	56,912	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.111411	4,175,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.398881	1,066,710	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		101,285,686	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)		101,285,686	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/24/2017 1:24 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		5,167,613		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.203266	23,505	4,778	50.00
50.01	03330 ENDOSCOPY	0.107332	10,854	1,165	50.01
51.00	05100 RECOVERY ROOM	0.135099	7,018	948	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.586405	49	29	52.00
53.00	05300 ANESTHESIOLOGY	0.101424	12,690	1,287	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.200444	91,852	18,411	54.00
54.01	03630 ULTRASOUND	0.138479	68,049	9,423	54.01
54.02	03440 MAMMOGRAPHY	0.334280	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	03480 ONCOLOGY	0.000000	0	0	55.01
56.00	05600 RADIOISOTOPE	0.153904	18	3	56.00
57.00	05700 CT SCAN	0.039642	139,948	5,548	57.00
58.00	05800 MRI	0.075402	114,081	8,602	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.230898	35,694	8,242	59.00
60.00	06000 LABORATORY	0.122526	779,022	95,450	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.299551	10,917	3,270	63.00
65.00	06500 RESPIRATORY THERAPY	0.104122	735,111	76,541	65.00
66.00	06600 PHYSICAL THERAPY	0.177857	1,816,070	323,001	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.199609	1,657,486	330,849	67.00
68.00	06800 SPEECH PATHOLOGY	0.284986	324,291	92,418	68.00
69.01	03140 CARDIOLOGY	0.111243	57,404	6,386	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.223570	473,854	105,940	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.212478	1,703	362	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.068759	2,064,964	141,985	73.00
74.00	07400 RENAL DIALYSIS	0.590822	70,583	41,702	74.00
76.97	07697 CARDIAC REHABILITATION	0.600024	6,898	4,139	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.111411	64,871	7,227	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.398881	40,949	16,334	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		8,607,881	1,304,040	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)		8,607,881		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 1:24 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)		14,784,305	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,434,276	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)		722,005	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		7,537,818	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		163.51	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)		9.59	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)		0.09	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)		9.50	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		9.03	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)		9.03	12.00
13.00	Total allowable FTE count for the prior year.		9.50	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.		9.50	14.00
15.00	Sum of lines 12 through 14 divided by 3.		9.34	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		9.34	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.057122	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.058239	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.057122	21.00
22.00	IME payment adjustment (see instructions)		590,337	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		231,539	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).		1.19	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-0.47	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)		590,337	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		231,539	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.80	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.73	31.00
32.00	Sum of lines 30 and 31		29.53	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.58	33.00
34.00	Disproportionate share adjustment (see instructions)		652,471	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 1:24 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)	0.000157009	0.000160346	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,005,824	958,464	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	752,994	241,586	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	994,580		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)	22,177,974		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)		22,409,513	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,769,088	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).		350,880	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,529,481	59.00
60.00	Primary payer payments		8,591	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,520,890	61.00
62.00	Deductibles billed to program beneficiaries		1,945,664	62.00
63.00	Coinurance billed to program beneficiaries		57,960	63.00
64.00	Allowable bad debts (see instructions)		257,517	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		167,386	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		212,363	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,684,652	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)		44,812	70.93
70.94	HRR adjustment amount (see instructions)		-330,268	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 1:24 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)			22,399,196	71.00
71.01	Sequestration adjustment (see instructions)			447,984	71.01
72.00	Interim payments			21,814,760	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)			136,452	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			105,433	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: 14-0113

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2017 1:24 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	14,784,305	0	14,784,305		14,784,305	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,434,276	0		4,434,276	4,434,276	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	722,005	0	389,843	332,162	722,005	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	7,537,818	0	0	7,537,818	7,537,818	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.057122	0.057122	0.057122	0.057122		5.00
6.00	IME payment adjustment (see instructions)	22.00	590,337	0	454,129	136,208	590,337	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	231,539	0	231,539	0	231,539	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	590,337	0	454,129	136,208	590,337	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	231,539	0	231,539	0	231,539	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1358	0.1358	0.1358	0.1358		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	652,471	0	501,927	150,544	652,471	11.00
11.01	Uncompensated care payments	36.00	994,580	0	895,678	252,830	1,148,508	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	22,177,974	0	16,871,954	5,306,020	22,177,974	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	22,409,513	0	17,103,493	5,306,020	22,409,513	15.00
16.00	Payment for inpatient program capital	50.00	1,769,088	0	1,359,667	409,421	1,769,088	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0113

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2017 1:24 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	18,463,160	5,715,441	24,178,601	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,542,448	0	1,185,480	356,968	1,542,448	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	68,539	0	52,675	15,864	68,539	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	0.0409	0.0409	0.0409	0.0409		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	63,086	0	48,486	14,600	63,086	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0616	0.0616	0.0616	0.0616		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	95,015	0	73,026	21,989	95,015	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,769,088	0	1,359,667	409,421	1,769,088	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: 14-0113		Period: From 01/01/2016 To 12/31/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2017 1:24 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. 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	14,784,305	14,784,305		14,784,305	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,434,276		4,434,276	4,434,276	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	722,005	389,843	332,162	722,005	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	7,537,818	0	7,537,818	7,537,818	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.057122	0.057122	0.057122		5.00
6.00	IME payment adjustment (see instructions)	22.00	590,337	454,129	136,208	590,337	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	231,539	0	231,539	231,539	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	590,337	454,129	136,208	590,337	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	231,539	0	231,539	231,539	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1358	0.1358	0.1358		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	652,471	501,927	150,544	652,471	11.00
11.01	Uncompensated care payments	36.00	994,580	752,994	241,586	994,580	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	22,177,974	16,883,198	5,294,776	22,177,974	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	22,409,513	16,883,198	5,526,315	22,409,513	15.00
16.00	Payment for inpatient program capital	50.00	1,769,088	1,359,667	409,421	1,769,088	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			18,242,865	5,935,736	24,178,601	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2017 1:24 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	1,542,448	1,185,480	356,968	1,542,448	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	68,539	52,675	15,864	68,539	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	0.0409	0.0409	0.0409		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	63,086	48,486	14,600	63,086	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0616	0.0616	0.0616		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	95,015	73,026	21,989	95,015	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,769,088	1,359,667	409,421	1,769,088	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	44,812	25,447	19,365	44,812	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	-330,268	-273,509	-56,759	-330,268	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: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/24/2017 1:24 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,440	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,977,756	2.00
3.00	PPS payments		8,511,195	3.00
4.00	Outlier payment (see instructions)		52,366	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,440	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		63,021	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)		63,021	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)		63,021	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		58,581	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,440	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)		8,563,561	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)		1,556,472	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)		7,011,529	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		132,782	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)		7,144,311	30.00
31.00	Primary payer payments		5,600	31.00
32.00	Subtotal (line 30 minus line 31)		7,138,711	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)		183,651	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		119,373	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		147,106	36.00
37.00	Subtotal (see instructions)		7,258,084	37.00
38.00	MSP-LCC reconciliation amount from PS&R		46	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)		7,258,038	40.00
40.01	Sequestration adjustment (see instructions)		145,161	40.01
41.00	Interim payments		7,090,094	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		22,783	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/24/2017 1:24 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		101	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		42	2.00
3.00	PPS payments		157	3.00
4.00	Outlier payment (see instructions)		0	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)		101	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,473	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)		1,473	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)		1,473	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,372	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)		101	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)		157	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)		0	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)		258	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)		258	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		258	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		258	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		258	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
41.00	Interim payments		299	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-46	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: 14-0113

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2017 1:24 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		21,983,830		7,155,821	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	12/22/2016	169,070	12/22/2016	65,727	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)		-169,070		-65,727	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)		21,814,760		7,090,094	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		136,452		22,783	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		21,951,212		7,112,877	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: 14-0113
Component CCN: 14-T113

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2017 1:24 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,207,518		299	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,207,518		299	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		20,626		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		46	6.02
7.00	Total Medicare program liability (see instructions)		4,228,144		253	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0113

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

Worksheet E-1
Part II
Date/Time Prepared:
5/24/2017 1:24 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	6,587	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	8,708	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,387	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	23,195	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	647,996,887	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	12,756,498	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)	410,574	8.00
9.00	Sequestration adjustment amount (see instructions)	8,211	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	402,363	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	422,668	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)	-20,305	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/24/2017 1:24 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,061,454 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0224 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			151,898 3.00
4.00	Outlier Payments			128,773 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)			12.062842 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)			4,342,125 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)			4,342,125 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,342,125 19.00
20.00	Deductibles			19,320 20.00
21.00	Subtotal (line 19 minus line 20)			4,322,805 21.00
22.00	Coinsurance			8,372 22.00
23.00	Subtotal (line 21 minus line 22)			4,314,433 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)			4,314,433 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)			4,314,433 32.00
32.01	Sequestration adjustment (see instructions)			86,289 32.01
33.00	Interim payments			4,207,518 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)			20,626 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,146,342 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			128,773 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2017 1:24 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,796,517		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,796,517	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,796,517	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		1,796,517	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,796,517	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0113 Component CCN: 14-T113	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2017 1:24 pm	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		162,011		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		162,011	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		162,011	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		162,011	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		162,011	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/24/2017 1:24 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			8.70	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			8.70	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			9.03	6.00
7.00	Enter the lesser of line 5 or line 6			8.70	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	9.03	0.00	9.03	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	8.70	0.00	8.70	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	8.70	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	8.70	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	8.70	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	8.70	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	8.70	0.00		17.00
18.00	Per resident amount	103,388.69	97,899.98		18.00
19.00	Approved amount for resident costs	899,482	0	899,482	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			1.99	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.33	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.33	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			100,050.08	23.00
24.00	Multiply line 22 time line 23			33,017	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			932,499	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	11,366	3,866		26.00
27.00	Total Inpatient Days (see instructions)	28,314	28,314		27.00
28.00	Ratio of inpatient days to total inpatient days	0.401427	0.136540		28.00
29.00	Program direct GME amount	374,330	127,323		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		17,991		30.00
31.00	Net Program direct GME amount			483,662	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/24/2017 1:24 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,051,199	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		26,372,307	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		8,591	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		26,363,716	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		9,982,339	42.00
43.00	Primary payer payments (see instructions)		5,600	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		9,976,739	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		36,340,455	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.725465	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.274535	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		483,662	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		350,880	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		132,782	50.00

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

Provider CCN: 14-0113

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

Worksheet G
Date/Time Prepared:
5/24/2017 1:24 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	4,108,457	0	0	0	1.00
2.00	Temporary investments	200,492	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	80,682,759	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-50,003,580	0	0	0	6.00
7.00	Inventory	3,026,556	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,755,890	0	0	0	9.00
10.00	Due from other funds	20,429,333	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	62,199,907	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,554,070	0	0	0	12.00
13.00	Land improvements	4,970,446	0	0	0	13.00
14.00	Accumulated depreciation	-4,220,490	0	0	0	14.00
15.00	Buildings	59,576,390	0	0	0	15.00
16.00	Accumulated depreciation	-42,316,968	0	0	0	16.00
17.00	Leasehold improvements	1,460,938	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	68,685,333	0	0	0	23.00
24.00	Accumulated depreciation	-58,017,168	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)	35,692,551	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,495,995	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	36,946	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,532,941	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	105,425,399	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,254,174	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	104,690	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	10,060,504	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,419,368	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	36,946	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,946	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,456,314	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	93,969,085	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	93,969,085	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	105,425,399	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0113

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

Worksheet G-1

Date/Time Prepared:
5/24/2017 1:24 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		75,241,776		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		14,948,708			2.00
3.00	Total (sum of line 1 and line 2)		90,190,484		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	NET ASSETS TRANSFERS	162,769		0		5.00
6.00	OTHER RESTRICTED NET ASSETS	3,615,835		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		3,778,604		0	10.00
11.00	Subtotal (line 3 plus line 10)		93,969,088		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	ROUNDING	3		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		3		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		93,969,085		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	NET ASSETS TRANSFERS		0			5.00
6.00	OTHER RESTRICTED NET ASSETS		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0113

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2017 1:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	53,680,289		53,680,289	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,579,606		8,579,606	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)	62,259,895		62,259,895	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	16,475,653		16,475,653	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)	16,475,653		16,475,653	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	78,735,548		78,735,548	17.00
18.00	Ancillary services	255,899,839	243,130,516	499,030,355	18.00
19.00	Outpatient services	12,664,988	44,710,834	57,375,822	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	0	12,855,158	12,855,158	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NON PATIENT CHARGES	348,903	1,807,935	2,156,838	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	347,649,278	302,504,443	650,153,721	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		128,764,575		29.00
30.00	ROUNDING ERROR	1			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)		1		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	ROUNDING	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)		128,764,576		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0113

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

Worksheet G-3

Date/Time Prepared:
5/24/2017 1:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	650,153,721	1.00
2.00	Less contractual allowances and discounts on patients' accounts	510,146,551	2.00
3.00	Net patient revenues (line 1 minus line 2)	140,007,170	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	128,764,576	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,242,594	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	109,038	6.00
7.00	Income from investments	691,449	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	318,486	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,587,137	24.00
24.01	ROUNDING	4	24.01
24.02		0	24.02
24.03		0	24.03
24.04		0	24.04
24.05		0	24.05
24.06		0	24.06
24.07		0	24.07
25.00	Total other income (sum of lines 6-24)	3,706,114	25.00
26.00	Total (line 5 plus line 25)	14,948,708	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.03	ROUNDING	0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,948,708	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0113	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/24/2017 1:24 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,542,448	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		68,539	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)		65.70	3.00
4.00	Number of interns & residents (see instructions)		9.34	4.00
5.00	Indirect medical education percentage (see instructions)		4.09	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)		63,086	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.80	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.73	8.00
9.00	Sum of lines 7 and 8		29.53	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.16	10.00
11.00	Disproportionate share adjustment (see instructions)		95,015	11.00
12.00	Total prospective capital payments (see instructions)		1,769,088	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