

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: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 8:26 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/24/2017 Time: 8:26 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 ADVOCATE BROMENN MEDICAL CENTER (14-0127) 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	282,918	87,652	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	33,704	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	316,622	87,652	0	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 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: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 8:22 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1304 VIRGINIA			PO Box:						1.00
2.00	City: NORMAL			State: IL		Zip Code: 61761-		County: MCLEAN		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	ADVOCATE BROMENN MEDICAL CENTER	140127	14060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ADVOCATE BROMENN REHABILITATION	14T127	14060	5	07/01/1990	N	P	O	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 - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2016		12/31/2016		20.00
21.00	Type of Control (see instructions)					1				21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,290	1,234	0	0	3,872	0			24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	110	0	0	191				25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 8:22 am			
		Urban/Rural	St	Date of Geogra			
		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)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N		Y	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N	N	46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N	N	48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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)	Y				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)						Y	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
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)						0.16	6.98	0.022409	64.00
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)						1.50	5.17	0.224888	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)	0.50	9.85	0.048309		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)	FAMILY PRACTICE - OSTEOPATHIC	3630	0.06	6.41	0.009274 67.00	
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	76.00
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 (11)" 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)	N				106.00			
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00			
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00			
		Physical		Occupational		Speech		Respiratory	
		1.00		2.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		N		N	
								1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.							N	
								1.00	
								2.00	
								3.00	
Miscellaneous Cost Reporting Information									
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N						116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	151,272		100,000		-55,430		118.01	
								1.00	
								2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N						118.02	
119.00	DO NOT USE THIS LINE							119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y						121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N						122.00	
Transplant Center Information									
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N						125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 8:22 am	
		1.00	2.00				
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	14H036				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: ADVOCATE HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 3075 HIGHLAND PKWY	PO Box: SUITE 600				142.00	
143.00	City: DOWNERS GROVE	State: IL		Zip Code: 60515		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	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	
161.10	CORF		N	N	N	161.10	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	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	
168.01	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)					9.99	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 8:22 am	
			Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		01/01/2016	12/31/2016	170.00
			1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 8:22 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		03/06/2015		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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			2.00
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.				Y		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/17/2017	Y	04/17/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 8:22 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAMELA		DYE	41.00
42.00	Enter the employer/company name of the cost report preparer	ADVOCATE HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5760		PAMELA.DYE@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0127

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

Worksheet S-2
Part II
Date/Time Prepared:
5/24/2017 8:22 am

		3.00	
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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.	SENIOR REIMBURSEMENT SPECIALIST	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: 14-0127

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 8:22 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	176	64,416	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)		176	64,416	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,980	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)		206	75,396	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	15	5,490		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		221				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0127

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 8:22 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,641	1,547	20,287			1.00
2.00 HMO and other (see instructions)	3,290	3,872				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	191				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)	7,641	1,547	20,287			7.00
8.00 INTENSIVE CARE UNIT	3,407	366	7,560			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,444	4,103			13.00
14.00 Total (see instructions)	11,048	3,357	31,950	12.57	907.68	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	1,949	110	3,002	0.00	15.97	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	140			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
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)				12.57	923.65	27.00
28.00 Observation Bed Days		149	2,913			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			595			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	167	386			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			45			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0127

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 8:22 am

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	2,581	663	8,012	1.00
2.00 HMO and other (see instructions)			857	1,188		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				17		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	2,581	663	8,012	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	168	8	251	17.00
18.00 SUBPROVIDER	0.00	0		0	0	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
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: 14-0127

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2017 8:22 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	56,384,582	0	56,384,582	1,921,192.00	29.35
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		131,415	0	131,415	824.00	159.48
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		12,725	0	12,725	1.00	12,725.00
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	1,547,130	0	1,547,130	52,915.00	29.24
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,119,546	-113,311	2,006,235	91,896.00	21.83
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		702,401	0	702,401	10,080.64	69.68
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		2,759,917	0	2,759,917	26,718.00	103.30
14.00	Home office and/or related organization salaries and wage-related costs		8,794,204	0	8,794,204	137,560.00	63.93
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,753,982	0	14,753,982		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		564,756	0	564,756		
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		27,521	0	27,521		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		3,562	0	3,562		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		433,065	0	433,065		
25.50	Home office wage-related		1,983,538	0	1,983,538		
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	1,389,429	-1,182,432	206,997	8,486.00	24.39
27.00	Administrative & General	5.00	6,882,148	946,618	7,828,766	227,116.00	34.47
28.00	Administrative & General under contract (see inst.)		694,052	0	694,052	13,373.00	51.90
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0127

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2017 8:22 am

	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	
30.00	Operation of Plant	7.00 993,627	10,691	1,004,318	33,144.00	30.30	30.00
31.00	Laundry & Linen Service	8.00 321,970	-14,426	307,544	24,143.00	12.74	31.00
32.00	Housekeeping	9.00 1,169,003	15,239	1,184,242	90,189.00	13.13	32.00
33.00	Housekeeping under contract (see instructions)	770	0	770	10.50	73.33	33.00
34.00	Dietary	10.00 979,026	-421,890	557,136	37,579.00	14.83	34.00
35.00	Dietary under contract (see instructions)	50	0	50	0.75	66.67	35.00
36.00	Cafeteria	11.00 0	432,269	432,269	27,962.00	15.46	36.00
37.00	Maintenance of Personnel	12.00 0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00 1,766,339	13,253	1,779,592	48,922.00	36.38	38.00
39.00	Central Services and Supply	14.00 336,273	3,304	339,577	20,904.00	16.24	39.00
40.00	Pharmacy	15.00 2,257,822	18,825	2,276,647	52,589.00	43.29	40.00
41.00	Medical Records & Medical Records Library	16.00 1,277,945	8,632	1,286,577	50,981.00	25.24	41.00
42.00	Social Service	17.00 1,219,471	9,812	1,229,283	33,072.00	37.17	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0127

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2017 8:22 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,519,599	0	55,519,599	1,881,660.25	29.51	1.00
2.00	Excluded area salaries (see instructions)	2,119,546	-113,311	2,006,235	91,896.00	21.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)	53,400,053	113,311	53,513,364	1,789,764.25	29.90	3.00
4.00	Subtotal other wages & related costs (see inst.)	12,256,522	0	12,256,522	174,358.64	70.29	4.00
5.00	Subtotal wage-related costs (see inst.)	16,765,041	0	16,765,041	0.00	31.33	5.00
6.00	Total (sum of lines 3 thru 5)	82,421,616	113,311	82,534,927	1,964,122.89	42.02	6.00
7.00	Total overhead cost (see instructions)	19,287,925	-160,105	19,127,820	668,471.25	28.61	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2017 8:22 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,356,647	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)	1,740,194	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	133,210	6.00
7.00	Employee Managed Care Program Administration Fees	628,306	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	4,526,897	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,435,525	9.00
10.00	Dental, Hearing and Vision Plan	282,632	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67,100	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)	348,279	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	716,281	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,974,848	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	69,872	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))	231,122	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	271,973	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,782,886	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS(SPECIFY)	162,986	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/24/2017 8:22 am
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		702,401	15,782,886
2.00	Hospital		702,401	14,753,982
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF		0	248,554
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		0	0
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice		0	0
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
17.00	Renal Dialysis			
18.00	Other		0	780,350

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/24/2017 8:22 am
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.285213	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		5,506,007		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		67,391,040		6.00	
7.00	Medicaid cost (line 1 times line 6)		19,220,801		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)		13,714,794		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)		13,714,794		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)		5,223,151	7,259,362	12,482,513	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)		1,489,711	2,070,464	3,560,175	21.00
22.00	Partial payment by patients approved for charity care		8,467	46,374	54,841	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,481,244	2,024,090	3,505,334	23.00
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,355,224			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		501,881			27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		5,853,343			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,669,450			29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,174,784			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		18,889,578			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

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

Worksheet A
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		5,561,686	5,561,686	0	5,561,686	1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,920,063	4,920,063	2.00	
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,389,429	11,603,473	12,992,902	-1,344,044	11,648,858	4.00	
5.00 00500 ADMIN STRATIVE & GENERAL	6,882,148	32,970,999	39,853,147	329,682	40,182,829	5.00	
7.00 00700 OPERATION OF PLANT	993,627	5,084,729	6,078,356	-193,200	5,885,156	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	321,970	353,772	675,742	-79,270	596,472	8.00	
9.00 00900 HOUSEKEEPING	1,169,003	756,390	1,925,393	-11,811	1,913,582	9.00	
10.00 01000 DIETARY	979,026	1,023,449	2,002,475	-893,715	1,108,760	10.00	
11.00 01100 CAFETERIA	0	0	0	860,257	860,257	11.00	
13.00 01300 NURSING ADMINISTRATION	1,766,339	257,735	2,024,074	3,424	2,027,498	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	336,273	718,830	1,055,103	-428,707	626,396	14.00	
15.00 01500 PHARMACY	2,257,822	7,128,861	9,386,683	-106,141	9,280,542	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,277,945	535,623	1,813,568	321	1,813,889	16.00	
17.00 01700 SOCIAL SERVICE	1,219,471	298,144	1,517,615	6,887	1,524,502	17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1,547,130	0	1,547,130	0	1,547,130	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	302,313	302,313	5,842	308,155	22.00	
23.00 02300 CLINICAL PASTORAL EDUCATION	359,571	62,231	421,802	-127,254	294,548	23.00	
23.01 02301 EMS PROGRAM	0	0	0	0	0	23.01	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	12,313,096	7,960,795	20,273,891	-3,855,770	16,418,121	30.00	
31.00 03100 INTENSIVE CARE UNIT	3,493,695	1,490,620	4,984,315	-670,929	4,313,386	31.00	
40.00 04000 SUBPROVIDER - I PF	0	0	0	0	0	40.00	
41.00 04100 SUBPROVIDER - I RF	896,173	155,967	1,052,140	6,894	1,059,034	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	2,443,662	2,443,662	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,482,852	16,759,743	20,242,595	-12,361,729	7,880,866	50.00	
51.00 05100 RECOVERY ROOM	592,203	85,307	677,510	-37,466	640,044	51.00	
53.00 05300 ANESTHESIOLOGY	37,026	565,790	602,816	-345,525	257,291	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,290,841	1,654,587	3,945,428	-1,214,595	2,730,833	54.00	
57.00 05700 CT SCAN	419,265	486,538	905,803	-363,521	542,282	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,929,322	3,202,312	5,131,634	-2,004,310	3,127,324	60.00	
65.00 06500 RESPIRATORY THERAPY	853,809	247,333	1,101,142	-155,272	945,870	65.00	
66.00 06600 PHYSICAL THERAPY	1,288,057	297,787	1,585,844	-29,982	1,555,862	66.00	
67.00 06700 OCCUPATIONAL THERAPY	343,335	28,780	372,115	-606	371,509	67.00	
68.00 06800 SPEECH PATHOLOGY	229,606	19,524	249,130	-188	248,942	68.00	
69.00 06900 ELECTROCARDIOLOGY	1,673,647	3,124,081	4,797,728	-2,608,418	2,189,310	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	76,623	90,990	167,613	-8,487	159,126	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,654,797	9,654,797	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,774,400	9,774,400	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.97 07697 CARDIAC REHABILITATION	340,577	47,244	387,821	-13,319	374,502	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	548,361	71,453	619,814	-5,151	614,663	90.00	
90.01 09001 BASIC DIAGNOSTIC TESTING	451,892	52,927	504,819	-504,819	0	90.01	
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	0	90.03	
90.04 09003 WOUND CARE CLINIC	512,119	830,966	1,343,085	-258,070	1,085,015	90.04	
91.00 09100 EMERGENCY	3,248,527	3,568,463	6,816,990	-374,819	6,442,171	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
113.00 11300 INTEREST EXPENSE		3,032,551	3,032,551	0	3,032,551	113.00	
116.00 11600 HOSPICE	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,520,780	110,431,993	165,952,773	9,111	165,961,884	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	395,124	664,537	1,059,661	-6,349	1,053,312	190.00	
190.01 19001 OTHER NONREIMBURSABLE	468,678	1,612,460	2,081,138	-2,762	2,078,376	190.01	
190.13 19007 EUREKA	0	0	0	0	0	190.13	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
200.00	TOTAL (SUM OF LINES 118-199)	56,384,582	112,708,990	169,093,572	0	169,093,572	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

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

Worksheet A
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	512,306	6,073,992	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	966,473	5,886,536	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-484,065	11,164,793	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,459,102	19,723,727	5.00
7.00	00700	OPERATION OF PLANT	-3,703	5,881,453	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-228,422	368,050	8.00
9.00	00900	HOUSEKEEPING	-35,460	1,878,122	9.00
10.00	01000	DIETARY	-956	1,107,804	10.00
11.00	01100	CAFETERIA	-344,779	515,478	11.00
13.00	01300	NURSING ADMINISTRATION	-16,832	2,010,666	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-5	626,391	14.00
15.00	01500	PHARMACY	-63,539	9,217,003	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,516	1,811,373	16.00
17.00	01700	SOCIAL SERVICE	0	1,524,502	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,547,130	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	40,180	348,335	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	-6,297	288,251	23.00
23.01	02301	EMS PROGRAM	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,906,806	12,511,315	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,313,386	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,059,034	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-4,200	2,439,462	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,430,696	5,450,170	50.00
51.00	05100	RECOVERY ROOM	0	640,044	51.00
53.00	05300	ANESTHESIOLOGY	-165,639	91,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-29,371	2,701,462	54.00
57.00	05700	CT SCAN	27,046	569,328	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-289,237	2,838,087	60.00
65.00	06500	RESPIRATORY THERAPY	0	945,870	65.00
66.00	06600	PHYSICAL THERAPY	42,157	1,598,019	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,637	395,146	67.00
68.00	06800	SPEECH PATHOLOGY	18,138	267,080	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,189,310	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	159,126	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,654,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,774,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	374,502	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	88,400	703,063	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	90.03
90.04	09003	WOUND CARE CLINIC	61,076	1,146,091	90.04
91.00	09100	EMERGENCY	-2,675,160	3,767,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	-3,032,551	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-32,399,923	133,561,961	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,053,312	190.00
190.01	19001	OTHER NONREIMBURSABLE	222,037	2,300,413	190.01
190.13	19007	EUREKA	0	0	190.13
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-32,177,886	136,915,686	200.00

RECLASSIFICATIONS

Provider CCN: 14-0127

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

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NURSERY EXPENSE					
1.00	NURSERY	43.00	2,140,596	628,543	1.00
	TOTALS		2,140,596	628,543	
B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	427,734	427,988	1.00
	TOTALS		427,734	427,988	
C - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,429,197	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	27,633	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
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
	TOTALS		0	19,456,830	
D - MANAGEMENT COMPENSATION RECLASS					
1.00		0.00	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	683,183	0	2.00
3.00	OPERATION OF PLANT	7.00	14,502	0	3.00
4.00	PHARMACY	15.00	19,810	0	4.00
5.00	SOCIAL SERVICE	17.00	5,535	0	5.00
6.00	CLINICAL PASTORAL EDUCATION	23.00	5,880	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	34,023	0	7.00
8.00	NURSERY	43.00	36,174	0	8.00
9.00	OPERATING ROOM	50.00	22,742	0	9.00
10.00	ANESTHESIOLOGY	53.00	1,400	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	9,914	0	11.00
12.00	LABORATORY	60.00	5,725	0	12.00
13.00	RESPIRATORY THERAPY	65.00	5,001	0	13.00
14.00	PHYSICAL THERAPY	66.00	7,026	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	15,153	0	15.00
16.00	EMERGENCY	91.00	6,316	0	16.00
17.00	OTHER NONREIMBURSABLE	190.01	4,438	0	17.00
	TOTALS		876,822	0	
E - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	9,774,400	1.00
	TOTALS		0	9,774,400	
F - EQUIP DEPR EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,966,695	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

RECLASSIFICATIONS

Provider CCN: 14-0127

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

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
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
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
TOTALS			0	4,966,695	
G - BASIC DIAGNOSTIC TESTING					
1.00	OPERATING ROOM	50.00	424,778	46,945	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	4,519	499	2.00
3.00	LABORATORY	60.00	13,557	1,498	3.00
4.00	ELECTROCARDIOLOGY	69.00	9,038	999	4.00
TOTALS			451,892	49,941	
H - RECLASS EUREKA ALLOCATED COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	83,242	203,127	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS			83,242	203,127	
I - A&G RELATED CPE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	135,406	0	1.00
TOTALS			135,406	0	
J - RECLASS MD CONTRACT EXPENSES					
1.00	ADULTS & PEDIATRICS	30.00	0	25,000	1.00
2.00	SUBPROVIDER - IRF	41.00	0	58,000	2.00
3.00	OPERATING ROOM	50.00	0	106,367	3.00
4.00	ELECTROCARDIOLOGY	69.00	0	12,300	4.00
5.00	WOUND CARE CLINIC	90.04	0	11,450	5.00
TOTALS			0	213,117	
K - ASSOCIATE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	44,787	0	1.00
2.00	OPERATION OF PLANT	7.00	7,427	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	4,199	0	3.00
4.00	HOUSEKEEPING	9.00	15,239	0	4.00
5.00	DIETARY	10.00	5,844	0	5.00
6.00	CAFETERIA	11.00	4,535	0	6.00
7.00	NURSING ADMINISTRATION	13.00	13,253	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	3,304	0	8.00
9.00	PHARMACY	15.00	9,214	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	8,632	0	10.00
11.00	SOCIAL SERVICE	17.00	4,277	0	11.00
12.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	7,426	0	12.00
13.00	CLINICAL PASTORAL EDUCATION	23.00	2,293	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	47,611	0	14.00
15.00	INTENSIVE CARE UNIT	31.00	18,384	0	15.00
16.00	SUBPROVIDER - IRF	41.00	3,537	0	16.00
17.00	NURSERY	43.00	11,776	0	17.00
18.00	OPERATING ROOM	50.00	16,599	0	18.00
19.00	RECOVERY ROOM	51.00	2,682	0	19.00
20.00	ANESTHESIOLOGY	53.00	272	0	20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	10,496	0	21.00
22.00	CT SCAN	57.00	1,749	0	22.00

RECLASSIFICATIONS

Provider CCN: 14-0127

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

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
23.00	LABORATORY	60.00	14,225	0		23.00
24.00	RESPIRATORY THERAPY	65.00	4,548	0		24.00
25.00	PHYSICAL THERAPY	66.00	5,209	0		25.00
26.00	OCCUPATIONAL THERAPY	67.00	1,749	0		26.00
27.00	SPEECH PATHOLOGY	68.00	1,127	0		27.00
28.00	ELECTROCARDIOLOGY	69.00	6,608	0		28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	505	0		29.00
30.00	CARDIAC REHABILITATION	76.97	2,099	0		30.00
31.00	CLINIC	90.00	1,944	0		31.00
32.00	WOUND CARE CLINIC	90.04	777	0		32.00
33.00	EMERGENCY	91.00	17,336	0		33.00
34.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	4,198	0		34.00
35.00	OTHER NONREIMBURSABLE	190.01	1,749	0		35.00
	TOTALS		305,610	0		
500.00	Grand Total: Increases		4,421,302	35,720,641		500.00

RECLASSIFICATIONS

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Period:
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To 12/31/2016

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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - NURSERY EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	2,140,596	628,543	0		1.00
	TOTALS		2,140,596	628,543			
B - CAFETERIA EXPENSE							
1.00	DIETARY	10.00	427,734	427,988	0		1.00
	TOTALS		427,734	427,988			
C - MEDICAL SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22,923	0		1.00
2.00	OPERATION OF PLANT	7.00	0	135,764	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	8,021	0		3.00
4.00	HOUSEKEEPING	9.00	0	7,376	0		4.00
5.00	DIETARY	10.00	0	9,114	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	3,825	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	398,005	0		7.00
8.00	PHARMACY	15.00	0	73,560	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	40	0		9.00
10.00	CLINICAL PASTORAL EDUCATION	23.00	0	21	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	664,405	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	390,321	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	47,702	0		13.00
14.00	NURSERY	43.00	0	186,631	0		14.00
15.00	OPERATING ROOM	50.00	0	12,266,130	0		15.00
16.00	RECOVERY ROOM	51.00	0	22,528	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	297,123	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	329,512	0		18.00
19.00	CT SCAN	57.00	0	197,118	0		19.00
20.00	LABORATORY	60.00	0	1,895,145	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	125,769	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	14,237	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	2,355	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	1,315	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	1,769,935	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,186	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	6,384	0		27.00
28.00	CLINIC	90.00	0	5,664	0		28.00
29.00	WOUND CARE CLINIC	90.04	0	269,483	0		29.00
30.00	EMERGENCY	91.00	0	293,030	0		30.00
31.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,958	0		31.00
32.00	BASIC DIAGNOSTIC TESTING	90.01	0	2,986	0		32.00
33.00	OTHER NONREIMBURSABLE	190.01	0	5,264	0		33.00
	TOTALS		0	19,456,830			
D - MANAGEMENT COMPENSATION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	876,822	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
	TOTALS		876,822	0	0		
E - IMPLANT RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,774,400	0		1.00
	TOTALS		0	9,774,400			
F - EQUIP DEPR EXPENSE							
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	637,504	0		2.00
3.00	OPERATION OF PLANT	7.00	0	68,127	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	36,622	0		4.00
5.00	HOUSEKEEPING	9.00	0	19,674	0		5.00
6.00	DIETARY	10.00	0	34,723	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	6,004	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	34,006	0		8.00

RECLASSIFICATIONS

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Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
9.00	PHARMACY	15.00	0	51,406	0		9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,271	0		10.00	
11.00	I&R SERVICES-OTHER PRGM COSTS	22.00	0	1,584	0		11.00	
	APPRVD							
13.00	ADULTS & PEDIATRICS	30.00	0	528,860	0		13.00	
14.00	INTENSIVE CARE UNIT	31.00	0	298,992	0		14.00	
15.00	SUBPROVIDER - IRF	41.00	0	6,941	0		15.00	
16.00	NURSERY	43.00	0	186,796	0		16.00	
17.00	OPERATING ROOM	50.00	0	713,030	0		17.00	
18.00	RECOVERY ROOM	51.00	0	17,620	0		18.00	
19.00	ANESTHESIOLOGY	53.00	0	50,074	0		19.00	
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	884,430	0		20.00	
21.00	CT SCAN	57.00	0	168,152	0		21.00	
22.00	LABORATORY	60.00	0	127,071	0		22.00	
23.00	RESPIRATORY THERAPY	65.00	0	39,052	0		23.00	
24.00	PHYSICAL THERAPY	66.00	0	27,980	0		24.00	
26.00	ELECTROCARDIOLOGY	69.00	0	882,581	0		26.00	
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,806	0		27.00	
28.00	CARDIAC REHABILITATION	76.97	0	9,034	0		28.00	
29.00	CLINIC	90.00	0	1,431	0		29.00	
30.00	WOUND CARE CLINIC	90.04	0	814	0		30.00	
31.00	EMERGENCY	91.00	0	105,441	0		31.00	
32.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	7,589	0		32.00	
33.00	OTHER NONREIMBURSABLE	190.01	0	3,685	0		33.00	
34.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,395	0		34.00	
	TOTALS		0	4,966,695				
G - BASIC DIAGNOSTIC TESTING								
1.00	BASIC DIAGNOSTIC TESTING	90.01	451,892	49,941	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
	TOTALS		451,892	49,941				
H - RECLASS EUREKA ALLOCATED COSTS								
1.00		0.00	0	0	0		1.00	
2.00	OPERATION OF PLANT	7.00	11,238	0	0		2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	26,081	0	0		3.00	
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	136,294	0		4.00	
5.00	PHARMACY	15.00	10,199	0	0		5.00	
6.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	46,632	9		6.00	
7.00	LABORATORY	60.00	17,099	0	0		7.00	
8.00	LAUNDRY & LINEN SERVICE	8.00	18,625	20,201	0		8.00	
	TOTALS		83,242	203,127				
I - A&G RELATED CPE COSTS								
1.00	CLINICAL PASTORAL EDUCATION	23.00	135,406	0	0		1.00	
	TOTALS		135,406	0				
J - RECLASS MD CONTRACT EXPENSES								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	210,192	0		1.00	
2.00	SOCIAL SERVICE	17.00	0	2,925	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
5.00		0.00	0	0	0		5.00	
	TOTALS		0	213,117				
K - ASSOCIATE BONUS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	305,610	0	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
5.00		0.00	0	0	0		5.00	
6.00		0.00	0	0	0		6.00	
7.00		0.00	0	0	0		7.00	
8.00		0.00	0	0	0		8.00	
9.00		0.00	0	0	0		9.00	
10.00		0.00	0	0	0		10.00	
11.00		0.00	0	0	0		11.00	
12.00		0.00	0	0	0		12.00	
13.00		0.00	0	0	0		13.00	
14.00		0.00	0	0	0		14.00	
15.00		0.00	0	0	0		15.00	
16.00		0.00	0	0	0		16.00	
17.00		0.00	0	0	0		17.00	
18.00		0.00	0	0	0		18.00	
19.00		0.00	0	0	0		19.00	
20.00		0.00	0	0	0		20.00	

RECLASSIFICATIONS

Provider CCN: 14-0127

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

Worksheet A-6

Date/Time Prepared:
5/24/2017 8:22 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
	TOTALS		305,610	0			
500.00	Grand Total : Decreases		4,421,302	35,720,641			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2017 8:22 am

	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	7,844,000	0	0	0	1.00
2.00	Land Improvements	9,825,206	22,468	0	22,468	2.00
3.00	Buildings and Fixtures	235,901,711	2,342,032	0	2,342,032	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	82,540,293	2,268,444	0	2,268,444	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	336,111,210	4,632,944	0	4,632,944	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	336,111,210	4,632,944	0	4,632,944	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,844,000	0			1.00
2.00	Land Improvements	9,847,674	4,541,902			2.00
3.00	Buildings and Fixtures	238,206,066	118,096,556			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	84,258,632	48,540,740			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	340,156,372	171,179,198			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	340,156,372	171,179,198			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,561,686	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,561,686	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	NEW CAP REL COSTS-BLDG & FIXT	0	5,561,686				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,561,686				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	255,897,740	0	255,897,740	0.752294	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	84,258,632	0	84,258,632	0.247706	0	2.00
3.00	Total (sum of lines 1-2)	340,156,372	0	340,156,372	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	6,073,992	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	5,886,536	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,960,528	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	6,073,992	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,886,536	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	11,960,528	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

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

Worksheet A-8

Date/Time Prepared:
5/24/2017 8:22 am

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	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00 Investment income - other (chapter 2)		0		0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0 7.00
8.00 Television and radio service (chapter 21)		0		0.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-9,488,222			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	-6,552,466			0 12.00
13.00 Laundry and linen service	B	-228,422	LAUNDRY & LINEN SERVICE	8.00	0 13.00
14.00 Cafeteria-employees and guests	B	-351,535	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	B	-62,916	PHARMACY	15.00	0 17.00
18.00 Sale of medical records and abstracts	B	-2,437	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		RESPIRATORY THERAPY	65.00	0 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00	0 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	0 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	0 28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00	0 30.00
30.99 Hospice (non-distinct) (see instructions)	B	-70,000	ADULTS & PEDIATRICS	30.00	0 30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00	0 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00 MISCELLANEOUS INCOME	B	-4,463	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.00
33.03 MISCELLANEOUS INCOME	B	-210,786	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 MISCELLANEOUS INCOME	B	-2,776	OPERATION OF PLANT	7.00	0 33.04
33.08 MISCELLANEOUS INCOME	B	-35,460	HOUSEKEEPING	9.00	0 33.08

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

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

Worksheet A-8

Date/Time Prepared:
5/24/2017 8:22 am

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	
33.09	MI SCCELLANEOUS INCOME	B	-16,832	NURSING ADMINISTRATION	13.00	0 33.09
33.10	MI SCCELLANEOUS INCOME	B	-4,800	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0 33.10
33.19	MI SCCELLANEOUS INCOME	B	-5,459	CLINICAL PASTORAL EDUCATION	23.00	0 33.19
33.20	MI SCCELLANEOUS INCOME	B	-4,970	ADULTS & PEDIATRICS	30.00	0 33.20
33.21	MI SCCELLANEOUS INCOME	B	-4,200	NURSERY	43.00	0 33.21
33.22	MI SCCELLANEOUS INCOME	B	-124,642	OPERATING ROOM	50.00	0 33.22
33.24			0		0.00	0 33.24
33.25	MI SCCELLANEOUS INCOME	B	-289,929	LABORATORY	60.00	0 33.25
33.28	MI SCCELLANEOUS INCOME	B	-51,384	PHYSICAL THERAPY	66.00	0 33.28
34.00	MI SCCELLANEOUS INCOME	B	-3,600	CLINIC	90.00	0 34.00
35.00			0		0.00	0 35.00
35.01			0		0.00	0 35.01
35.02			0		0.00	0 35.02
35.03	INTEREST EXPENSE	A	-3,032,551	INTEREST EXPENSE	113.00	11 35.03
35.04	PA ASSESSMENT EXPENSE	A	-7,337,015	ADMINISTRATIVE & GENERAL	5.00	0 35.04
35.05	CONTRIBUTIONS	A	-550	ADMINISTRATIVE & GENERAL	5.00	0 35.05
35.06	SELF INSURANCE EXPENSE	A	-2,958,478	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 35.06
35.07			0		0.00	0 35.07
35.08	NON ALLOWABLE EXPENSES	A	-1,091,737	ADMINISTRATIVE & GENERAL	5.00	0 35.08
35.09	NON ALLOWABLE EXPENSES	A	-927	OPERATION OF PLANT	7.00	0 35.09
36.00	NON ALLOWABLE EXPENSES	A	-956	DIETARY	10.00	0 36.00
36.01	NON ALLOWABLE EXPENSES	A	-623	PHARMACY	15.00	0 36.01
36.02	NON ALLOWABLE EXPENSES	A	-79	MEDICAL RECORDS & LIBRARY	16.00	0 36.02
36.03	NON ALLOWABLE EXPENSES	A	-5,973	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0 36.03
36.04	NON ALLOWABLE EXPENSES	A	-838	CLINICAL PASTORAL EDUCATION	23.00	0 36.04
36.05	NON ALLOWABLE EXPENSES	A	-25,736	ADULTS & PEDIATRICS	30.00	0 36.05
36.06	NON ALLOWABLE EXPENSES	A	-61,884	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 36.06
36.07	NON ALLOWABLE EXPENSES	A	-713	WOUND CARE CLINIC	90.04	0 36.07
36.09	NON ALLOWABLE EXPENSES	A	-2,720	EMERGENCY	91.00	0 36.09
36.10	NON ALLOWABLE EXPENSES	A	-140,371	ADMINISTRATIVE & GENERAL	5.00	0 36.10
36.11	NON ALLOWABLE EXPENSES	A	-5	CENTRAL SERVICES & SUPPLY	14.00	0 36.11
36.13	NON ALLOWABLE EXPENSES	A	-249	PHYSICAL THERAPY	66.00	0 36.13
36.14			0		0.00	0 36.14
36.15	MARKETING OFFSET	A	-37,513	ADMINISTRATIVE & GENERAL	5.00	0 36.15
36.16	EUREKA OVERALLOCATION	A	-110,194	ADMINISTRATIVE & GENERAL	5.00	0 36.16
36.17	LOBBYING FEES	A	5,855	ADMINISTRATIVE & GENERAL	5.00	0 36.17
36.18			0		0.00	0 36.18
36.19			0		0.00	0 36.19
37.00			0		0.00	0 37.00
38.00			0		0.00	0 38.00
39.00			0		0.00	0 39.00
40.00			0		0.00	0 40.00
41.00			0		0.00	0 41.00
42.00			0		0.00	0 42.00
43.00			0		0.00	0 43.00
44.00			0		0.00	0 44.00
44.01			0		0.00	0 44.01
44.02			0		0.00	0 44.02
44.03			0		0.00	0 44.03
44.04	ADJ BOOK TO MC DEPR	A	172,278	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.04
44.05	ADJ BOOK TO MC DEPR	A	-31,608	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9 44.05
45.00			0		0.00	0 45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,177,886			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: 14-0127

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

Worksheet A-8-1

Date/Time Prepared: 5/24/2017 8:22 am

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	54.00	RADIOLOGY-DIAGNOSTIC	ADVANCED MRI	75,994	87,500	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BUILDING RENTAL	67,361	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	BUILDING RENTAL	72,169	5,900	3.01
3.02	11.00	CAFETERIA	BUILDING RENTAL	6,756	0	3.02
3.03	22.00	I&R SERVICES-OTHER PRGM COST	BUILDING RENTAL	50,953	0	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	BUILDING RENTAL	35,146	53,011	3.04
3.05	57.00	CT SCAN	BUILDING RENTAL	58,238	18,467	3.05
3.06	60.00	LABORATORY	BUILDING RENTAL	41,047	40,355	3.06
3.07	66.00	PHYSICAL THERAPY	BUILDING RENTAL	231,493	137,703	3.07
3.08	67.00	OCCUPATIONAL THERAPY	BUILDING RENTAL	23,637	0	3.08
3.09	68.00	SPEECH PATHOLOGY	BUILDING RENTAL	18,138	0	3.09
3.10	90.00	CLINIC	BUILDING RENTAL	92,000	0	3.10
3.11	90.04	WOUND CARE CLINIC	BUILDING RENTAL	61,789	0	3.11
3.12	190.01	OTHER NONREIMBURSABLE	BUILDING RENTAL	228,616	6,579	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	340,028	0	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE	998,081	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,473,399	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4,454,052	15,531,848	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0			9,328,897	15,881,363	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	C		0.00	ADVANCED MRI	42.80	6.00
7.00	B		0.00	ADVOCATE HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00	B		0.00	ADVOCATE HEALTH CARE	100.00	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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0127

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2017 8:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	525,264	525,264	0	171,400	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	3,806,100	3,806,100	0	171,400	0	2.00
3.00	50.00	OPERATING ROOM	2,306,054	2,306,054	0	171,400	0	3.00
4.00	53.00	ANESTHESIOLOGY	165,639	165,639	0	171,400	0	4.00
5.00	57.00	CT SCAN	12,725	12,725	0	171,400	0	5.00
6.00	91.00	EMERGENCY	2,672,440	2,672,440	0	171,400	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			9,488,222	9,488,222	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	525,264	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,806,100	2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,306,054	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	165,639	4.00
5.00	57.00	CT SCAN	0	0	0	12,725	5.00
6.00	91.00	EMERGENCY	0	0	0	2,672,440	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	9,488,222	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	6,073,992	6,073,992				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	5,886,536		5,886,536			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11,164,793	41,890	2,839	11,209,522		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	19,723,727	573,100	755,572	1,563,161	22,615,560	5.00
7.00 00700 OPERATION OF PLANT	5,881,453	1,507,414	80,744	199,136	7,668,747	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	368,050	111,379	43,404	61,358	584,191	8.00
9.00 00900 HOUSEKEEPING	1,878,122	86,136	23,318	236,269	2,223,845	9.00
10.00 01000 DIETARY	1,107,804	40,656	41,154	111,155	1,300,769	10.00
11.00 01100 CAFETERIA	515,478	71,267	0	86,242	672,987	11.00
13.00 01300 NURSING ADMINISTRATION	2,010,666	57,156	7,116	355,048	2,429,986	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	626,391	63,656	40,304	67,749	798,100	14.00
15.00 01500 PHARMACY	9,217,003	53,940	60,926	454,216	9,786,085	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,811,373	55,922	9,803	256,686	2,133,784	16.00
17.00 01700 SOCIAL SERVICE	1,524,502	2,265	0	245,255	1,772,022	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1,547,130	0	0	310,151	1,857,281	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	348,335	31,687	1,877	0	381,899	22.00
23.00 02300 CLINICAL PASTORAL EDUCATION	288,251	35,265	0	46,354	369,870	23.00
23.01 02301 EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	12,511,315	1,146,811	848,196	2,045,833	16,552,155	30.00
31.00 03100 INTENSIVE CARE UNIT	4,313,386	302,133	354,366	700,698	5,670,583	31.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	1,059,034	125,727	8,226	179,502	1,372,489	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	2,439,462	58,843	0	436,639	2,934,944	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,450,170	325,122	845,085	787,464	7,407,841	50.00
51.00 05100 RECOVERY ROOM	640,044	28,233	20,883	120,144	809,304	51.00
53.00 05300 ANESTHESIOLOGY	91,652	5,889	59,348	7,721	164,610	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,701,462	158,127	1,048,227	456,818	4,364,634	54.00
57.00 05700 CT SCAN	569,328	54,574	199,294	83,997	907,193	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	2,838,087	172,374	150,605	388,194	3,549,260	60.00
65.00 06500 RESPIRATORY THERAPY	945,870	54,970	46,285	172,249	1,219,374	65.00
66.00 06600 PHYSICAL THERAPY	1,598,019	155,579	33,163	259,423	2,046,184	66.00
67.00 06700 OCCUPATIONAL THERAPY	395,146	14,700	0	68,848	478,694	67.00
68.00 06800 SPEECH PATHOLOGY	267,080	11,279	0	46,034	324,393	68.00
69.00 06900 ELECTROCARDIOLOGY	2,189,310	118,638	1,046,037	340,056	3,694,041	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	159,126	11,019	8,066	15,388	193,599	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,654,797	0	0	0	9,654,797	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9,774,400	0	0	0	9,774,400	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	374,502	30,633	10,707	68,368	484,210	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	703,063	57,213	1,696	109,792	871,764	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	1,146,091	42,479	965	102,328	1,291,863	90.04
91.00 09100 EMERGENCY	3,767,011	187,798	124,969	652,836	4,732,614	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	133,561,961	5,793,874	5,873,175	11,035,112	133,094,072	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,053,312	131,503	8,994	79,669	1,273,478	190.00
190.01 19001 OTHER NONREIMBURSABLE	2,300,413	148,615	4,367	94,741	2,548,136	190.01
190.13 19007 EUREKA	0	0	0	0	0	190.13
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
200.00 Cross Foot Adjustments						0 200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	136,915,686	6,073,992	5,886,536	11,209,522	136,915,686	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/24/2017 8:22 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,615,560				5.00
7.00	00700	OPERATION OF PLANT	1,517,346	9,186,093			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,589	258,918	958,698		8.00
9.00	00900	HOUSEKEEPING	440,012	200,237	65,812	2,929,906	9.00
10.00	01000	DIETARY	257,371	94,511	2,254	0	1,654,905
11.00	01100	CAFETERIA	133,158	165,671	1,748	82,322	0
13.00	01300	NURSING ADMINISTRATION	480,799	132,868	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	157,913	147,979	0	78,787	0
15.00	01500	PHARMACY	1,936,285	125,392	0	80,422	0
16.00	01600	MEDICAL RECORDS & LIBRARY	422,193	129,999	0	3,049	0
17.00	01700	SOCIAL SERVICE	350,614	5,265	0	9,191	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	367,483	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	75,563	73,661	0	10,075	0
23.00	02300	CLINICAL PASTORAL EDUCATION	73,183	81,980	0	9,191	0
23.01	02301	EMS PROGRAM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,275,046	2,665,943	319,675	1,240,788	1,143,893
31.00	03100	INTENSIVE CARE UNIT	1,121,987	702,356	111,338	47,590	371,815
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	271,562	292,273	24,324	45,955	139,197
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	580,711	136,791	4,655	46,839	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,465,723	755,798	136,123	422,787	0
51.00	05100	RECOVERY ROOM	160,130	65,631	13,399	45,955	0
53.00	05300	ANESTHESIOLOGY	32,570	13,690	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	863,591	367,592	44,687	91,910	0
57.00	05700	CT SCAN	179,498	126,866	19,472	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	702,260	400,711	437	91,910	0
65.00	06500	RESPIRATORY THERAPY	241,267	127,787	0	9,191	0
66.00	06600	PHYSICAL THERAPY	404,860	361,669	20,897	45,867	0
67.00	06700	OCCUPATIONAL THERAPY	94,715	34,171	157	2,475	0
68.00	06800	SPEECH PATHOLOGY	64,185	26,221	0	884	0
69.00	06900	ELECTROCARDIOLOGY	730,907	275,793	26,115	55,146	0
70.00	07000	ELECTROENCEPHALOGRAPHY	38,306	25,615	1,800	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,910,308	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,933,973	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,821	0	0
76.97	07697	CARDIAC REHABILITATION	95,806	71,212	659	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	172,488	133,000	442	22,889	0
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0
90.04	09003	WOUND CARE CLINIC	255,609	98,749	10,310	61,642	0
91.00	09100	EMERGENCY	936,400	436,567	152,573	367,641	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,859,411	8,534,916	958,698	2,872,506	1,654,905
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	251,972	305,699	0	53,821	0
190.01	19001	OTHER NONREIMBURSABLE	504,177	345,478	0	3,579	0
190.13	19007	EUREKA	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	22,615,560	9,186,093	958,698	2,929,906	1,654,905

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,055,886					11.00
13.00	01300	NURSING ADMINISTRATION	34,729	3,078,382				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,858	5,334	1,202,971			14.00
15.00	01500	PHARMACY	37,449	6,292	13,197	11,985,122		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,237	23,252	2,116	0	2,750,630	16.00
17.00	01700	SOCIAL SERVICE	23,507	98,941	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	37,611	0	5,664	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	11,428	0	13,005	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	245,154	1,217,378	143,464	7,227	48,125	30.00
31.00	03100	INTENSIVE CARE UNIT	85,350	456,831	48,584	3,690	19,297	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	23,611	114,762	5,719	18	17,580	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	51,080	253,915	32,781	0	26,294	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87,745	386,656	143,292	128,698	398,998	50.00
51.00	05100	RECOVERY ROOM	11,207	57,950	518	3,747	22,405	51.00
53.00	05300	ANESTHESIOLOGY	1,316	5,813	14,158	55,834	52,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,229	779	38,753	6,439	293,418	54.00
57.00	05700	CT SCAN	8,989	0	4,659	34,518	322,559	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	56,669	2,517	43,519	519	318,172	60.00
65.00	06500	RESPIRATORY THERAPY	23,670	5,993	12,449	2,969	16,809	65.00
66.00	06600	PHYSICAL THERAPY	25,281	6,053	6,142	0	33,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,008	0	0	0	5,198	67.00
68.00	06800	SPEECH PATHOLOGY	4,376	0	289	0	2,212	68.00
69.00	06900	ELECTROCARDIOLOGY	28,652	29,545	33,702	125,128	181,704	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,567	0	29	0	6,348	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,502,131	334,039	73.00
76.97	07697	CARDIAC REHABILITATION	8,309	0	2,953	0	5,860	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12,182	10,787	5,542	47	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	11,074	13,064	6,256	0	67,355	90.04
91.00	09100	EMERGENCY	78,032	380,363	49,106	187,417	578,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,021,320	3,076,225	625,897	10,058,382	2,750,630	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,225	0	552,442	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	14,341	2,157	24,632	1,926,740	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	1,055,886	3,078,382	1,202,971	11,985,122	2,750,630	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

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

Worksheet B
Part I
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Cost Center Description	INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
	SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER			
		Y & FRINGES	PRGM COSTS			
	17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	2,259,540				17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,224,764			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		584,473		22.00
23.00 02300	CLINICAL PASTORAL EDUCATION	0			558,657	23.00
23.01 02301	EMS PROGRAM	0				0 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	797,327	2,224,764	584,473	261,312	0 30.00
31.00 03100	INTENSIVE CARE UNIT	391,268	0	0	116,215	0 31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	201,685	0	0	14,578	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	6,723	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	106,725	0 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	413	0 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	0	0	0	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	10,452	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	10,757	0	0	0	0 90.00
90.01 09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0 90.01
90.03 09002	PSYCH OUTPATIENT	0	0	0	0	0 90.03
90.04 09003	WOUND CARE CLINIC	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	851,780	0	0	43,048	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,259,540	2,224,764	584,473	552,743	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	OTHER NONREIMBURSABLE	0	0	0	5,914	0 190.01
190.13 19007	EUREKA	0	0	0	0	0 190.13
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

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

Worksheet B
Part I
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Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		17.00	21.00			
202.00 TOTAL (sum lines 118-201)	2,259,540	2,224,764	584,473	558,657	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/24/2017 8:22 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
23.01	02301				23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	30,726,724	-2,809,237	27,917,487	30.00
31.00	03100	9,146,904	0	9,146,904	31.00
40.00	04000	0	0	0	40.00
41.00	04100	2,523,753	0	2,523,753	41.00
42.00	04200	0	0	0	42.00
43.00	04300	4,074,733	0	4,074,733	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	11,440,386	0	11,440,386	50.00
51.00	05100	1,190,246	0	1,190,246	51.00
53.00	05300	340,559	0	340,559	53.00
54.00	05400	6,126,445	0	6,126,445	54.00
57.00	05700	1,603,754	0	1,603,754	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	5,165,974	0	5,165,974	60.00
65.00	06500	1,659,509	0	1,659,509	65.00
66.00	06600	2,950,214	0	2,950,214	66.00
67.00	06700	622,418	0	622,418	67.00
68.00	06800	422,560	0	422,560	68.00
69.00	06900	5,191,185	0	5,191,185	69.00
70.00	07000	267,264	0	267,264	70.00
71.00	07100	11,565,450	0	11,565,450	71.00
72.00	07200	11,708,373	0	11,708,373	72.00
73.00	07300	9,837,991	0	9,837,991	73.00
76.97	07697	669,009	0	669,009	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1,239,898	0	1,239,898	90.00
90.01	09001	0	0	0	90.01
90.03	09002	0	0	0	90.03
90.04	09003	1,815,922	0	1,815,922	90.04
91.00	09100	8,793,624	0	8,793,624	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	0	0	0	99.10
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
116.00	11600	0	0	0	116.00
118.00		129,082,895	-2,809,237	126,273,658	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	2,457,637	0	2,457,637	190.00
190.01	19001	5,375,154	0	5,375,154	190.01
190.13	19007	0	0	0	190.13
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	136,915,686	-2,809,237	134,106,449	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	41,890	2,839	44,729	44,729 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,601	573,100	755,572	1,353,273	6,237 5.00
7.00 00700	OPERATION OF PLANT	2,388	1,507,414	80,744	1,590,546	795 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	21,822	111,379	43,404	176,605	245 8.00
9.00 00900	HOUSEKEEPING	4,050	86,136	23,318	113,504	943 9.00
10.00 01000	DIETARY	31,839	40,656	41,154	113,649	443 10.00
11.00 01100	CAFETERIA	0	71,267	0	71,267	344 11.00
13.00 01300	NURSING ADMINISTRATION	0	57,156	7,116	64,272	1,417 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	63,656	40,304	103,960	270 14.00
15.00 01500	PHARMACY	0	53,940	60,926	114,866	1,812 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	55,922	9,803	65,725	1,024 16.00
17.00 01700	SOCIAL SERVICE	0	2,265	0	2,265	979 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,237 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	37,580	31,687	1,877	71,144	0 22.00
23.00 02300	CLINICAL PASTORAL EDUCATION	0	35,265	0	35,265	185 23.00
23.01 02301	EMS PROGRAM	0	0	0	0	0 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	148,940	1,146,811	848,196	2,143,947	8,166 30.00
31.00 03100	INTENSIVE CARE UNIT	74,948	302,133	354,366	731,447	2,796 31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - I/RF	29,841	125,727	8,226	163,794	716 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	58,843	0	58,843	1,742 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	79,241	325,122	845,085	1,249,448	3,142 50.00
51.00 05100	RECOVERY ROOM	0	28,233	20,883	49,116	479 51.00
53.00 05300	ANESTHESIOLOGY	0	5,889	59,348	65,237	31 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	140,511	158,127	1,048,227	1,346,865	1,823 54.00
57.00 05700	CT SCAN	18,467	54,574	199,294	272,335	335 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	55,897	172,374	150,605	378,876	1,549 60.00
65.00 06500	RESPIRATORY THERAPY	0	54,970	46,285	101,255	687 65.00
66.00 06600	PHYSICAL THERAPY	145,573	155,579	33,163	334,315	1,035 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	14,700	0	14,700	275 67.00
68.00 06800	SPEECH PATHOLOGY	0	11,279	0	11,279	184 68.00
69.00 06900	ELECTROCARDIOLOGY	0	118,638	1,046,037	1,164,675	1,357 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	11,019	8,066	19,085	61 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97 07697	CARDIAC REHABILITATION	0	30,633	10,707	41,340	273 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	57,213	1,696	58,909	438 90.00
90.01 09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0 90.01
90.03 09002	PSYCH OUTPATIENT	0	0	0	0	0 90.03
90.04 09003	WOUND CARE CLINIC	0	42,479	965	43,444	408 90.04
91.00 09100	EMERGENCY	0	187,798	124,969	312,767	2,605 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	815,698	5,793,874	5,873,175	12,482,747	44,033 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	131,503	8,994	140,497	318 190.00
190.01 19001	OTHER NONREIMBURSABLE	6,579	148,615	4,367	159,561	378 190.01
190.13 19007	EUREKA	0	0	0	0	0 190.13
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
200.00 20000	Cross Foot Adjustments	0	0	0	0	200.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	822,277	6,073,992	5,886,536	12,782,805	44,729	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 8:22 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,359,510			5.00
7.00	00700	OPERATION OF PLANT	91,212	1,682,553		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,948	47,424	231,222	8.00
9.00	00900	HOUSEKEEPING	26,450	36,676	15,873	193,446
10.00	01000	DIETARY	15,471	17,311	544	0
11.00	01100	CAFETERIA	8,005	30,345	422	5,435
13.00	01300	NURSING ADMINISTRATION	28,902	24,337	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	9,493	27,104	0	5,202
15.00	01500	PHARMACY	116,396	22,967	0	5,310
16.00	01600	MEDICAL RECORDS & LIBRARY	25,379	23,811	0	201
17.00	01700	SOCIAL SERVICE	21,076	964	0	607
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	22,091	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,542	13,492	0	665
23.00	02300	CLINICAL PASTORAL EDUCATION	4,399	15,016	0	607
23.01	02301	EMS PROGRAM	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	196,896	488,303	77,098	81,926
31.00	03100	INTENSIVE CARE UNIT	67,446	128,646	26,853	3,142
40.00	04000	SUBPROVIDER - I PF	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	16,324	53,534	5,866	3,034
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	34,908	25,055	1,123	3,093
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,109	138,434	32,831	27,914
51.00	05100	RECOVERY ROOM	9,626	12,021	3,232	3,034
53.00	05300	ANESTHESIOLOGY	1,958	2,507	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,913	67,329	10,778	6,068
57.00	05700	CT SCAN	10,790	23,237	4,696	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	42,215	73,395	105	6,068
65.00	06500	RESPIRATORY THERAPY	14,503	23,406	0	607
66.00	06600	PHYSICAL THERAPY	24,337	66,244	5,040	3,028
67.00	06700	OCCUPATIONAL THERAPY	5,694	6,259	38	163
68.00	06800	SPEECH PATHOLOGY	3,858	4,803	0	58
69.00	06900	ELECTROCARDIOLOGY	43,937	50,515	6,299	3,641
70.00	07000	ELECTROENCEPHALOGRAPHY	2,303	4,692	434	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,834	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	116,257	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	439	0
76.97	07697	CARDIAC REHABILITATION	5,759	13,043	159	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,369	24,361	107	1,511
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0
90.03	09002	PSYCH OUTPATIENT	0	0	0	0
90.04	09003	WOUND CARE CLINIC	15,365	18,087	2,487	4,070
91.00	09100	EMERGENCY	56,290	79,963	36,798	24,273
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,314,055	1,563,281	231,222	189,657
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,147	55,993	0	3,553
190.01	19001	OTHER NONREIMBURSABLE	30,308	63,279	0	236
190.13	19007	EUREKA	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,359,510	1,682,553	231,222	193,446

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	115,818					11.00
13.00	01300	3,809	122,737				13.00
14.00	01400	1,630	213	147,872			14.00
15.00	01500	4,108	251	1,622	267,332		15.00
16.00	01600	3,975	927	260	0	121,302	16.00
17.00	01700	2,578	3,945	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	4,126	0	696	0	0	22.00
23.00	02300	1,254	0	1,599	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,890	48,537	17,635	161	2,122	30.00
31.00	03100	9,362	18,214	5,972	82	851	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	2,590	4,576	703	0	775	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	5,603	10,124	4,029	0	1,160	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,625	15,416	17,614	2,871	17,595	50.00
51.00	05100	1,229	2,311	64	84	988	51.00
53.00	05300	144	232	1,740	1,245	2,318	53.00
54.00	05400	5,948	31	4,764	144	12,939	54.00
57.00	05700	986	0	573	770	14,225	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	6,216	100	5,349	12	14,031	60.00
65.00	06500	2,596	239	1,530	66	741	65.00
66.00	06600	2,773	241	755	0	1,467	66.00
67.00	06700	769	0	0	0	229	67.00
68.00	06800	480	0	36	0	98	68.00
69.00	06900	3,143	1,178	4,143	2,791	8,013	69.00
70.00	07000	172	0	4	0	280	70.00
71.00	07100	0	0	0	0	15	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	211,949	14,731	73.00
76.97	07697	911	0	363	0	258	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,336	430	681	1	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.03	09002	0	0	0	0	0	90.03
90.04	09003	1,215	521	769	0	2,970	90.04
91.00	09100	8,559	15,165	6,036	4,180	25,496	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		112,027	122,651	76,937	224,356	121,302	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,218	0	67,907	0	0	190.00
190.01	19001	1,573	86	3,028	42,976	0	190.01
190.13	19007	0	0	0	0	0	190.13
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		115,818	122,737	147,872	267,332	121,302	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description	INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
	SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER			
		Y & FRINGES	PRGM COSTS			
	17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	32,414			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	23,328		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	94,665	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	0	58,325	23.00
23.01	02301	EMS PROGRAM	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,438			30.00
31.00	03100	INTENSIVE CARE UNIT	5,613			31.00
40.00	04000	SUBPROVIDER - IPF	0			40.00
41.00	04100	SUBPROVIDER - IRF	2,893			41.00
42.00	04200	SUBPROVIDER	0			42.00
43.00	04300	NURSERY	96			43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0			50.00
51.00	05100	RECOVERY ROOM	0			51.00
53.00	05300	ANESTHESIOLOGY	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0			54.00
57.00	05700	CT SCAN	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0			59.00
60.00	06000	LABORATORY	0			60.00
65.00	06500	RESPIRATORY THERAPY	0			65.00
66.00	06600	PHYSICAL THERAPY	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0			67.00
68.00	06800	SPEECH PATHOLOGY	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0			73.00
76.97	07697	CARDIAC REHABILITATION	0			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	154			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0			90.01
90.03	09002	PSYCH OUTPATIENT	0			90.03
90.04	09003	WOUND CARE CLINIC	0			90.04
91.00	09100	EMERGENCY	12,220			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0			99.10
101.00	10100	HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0			110.00
111.00	11100	ISLET ACQUISITION	0			111.00
113.00	11300	INTEREST EXPENSE	0			113.00
116.00	11600	HOSPICE	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,414	0	0	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
190.01	19001	OTHER NONREIMBURSABLE	0			190.01
190.13	19007	EUREKA	0			190.13
191.00	19100	RESEARCH	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0			192.00
200.00		Cross Foot Adjustments	0	23,328	94,665	58,325
201.00		Negative Cost Centers	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description		INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
202.00	TOTAL (sum lines 118-201)	32,414	23,328	94,665	58,325	23.01	0202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/24/2017 8:22 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
23.01	02301				23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,205,016	0	3,205,016	30.00
31.00	03100	1,033,545	0	1,033,545	31.00
40.00	04000	0	0	0	40.00
41.00	04100	267,205	0	267,205	41.00
42.00	04200	0	0	0	42.00
43.00	04300	145,776	0	145,776	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,602,999	0	1,602,999	50.00
51.00	05100	82,184	0	82,184	51.00
53.00	05300	75,412	0	75,412	53.00
54.00	05400	1,508,602	0	1,508,602	54.00
57.00	05700	327,947	0	327,947	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	527,916	0	527,916	60.00
65.00	06500	145,630	0	145,630	65.00
66.00	06600	439,235	0	439,235	66.00
67.00	06700	28,127	0	28,127	67.00
68.00	06800	20,796	0	20,796	68.00
69.00	06900	1,289,692	0	1,289,692	69.00
70.00	07000	27,031	0	27,031	70.00
71.00	07100	114,849	0	114,849	71.00
72.00	07200	116,257	0	116,257	72.00
73.00	07300	227,119	0	227,119	73.00
76.97	07697	62,106	0	62,106	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	98,297	0	98,297	90.00
90.01	09001	0	0	0	90.01
90.03	09002	0	0	0	90.03
90.04	09003	89,336	0	89,336	90.04
91.00	09100	584,352	0	584,352	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	0	0	0	99.10
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
116.00	11600	0	0	0	116.00
118.00		12,019,429	0	12,019,429	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	285,633	0	285,633	190.00
190.01	19001	301,425	0	301,425	190.01
190.13	19007	0	0	0	190.13
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
200.00		176,318	0	176,318	200.00
201.00		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
202.00	TOTAL (sum lines 118-201)	12,782,805	0	12,782,805			202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	536,347				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		4,966,696			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,699	2,395	56,184,891		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	50,606	637,505	7,834,962	-22,615,560	114,300,126
7.00 00700	OPERATION OF PLANT	133,108	68,127	998,121	0	7,668,747
8.00 00800	LAUNDRY & LINEN SERVICE	9,835	36,622	307,544	0	584,191
9.00 00900	HOUSEKEEPING	7,606	19,674	1,184,242	0	2,223,845
10.00 01000	DIETARY	3,590	34,723	557,137	0	1,300,769
11.00 01100	CAFETERIA	6,293	0	432,268	0	672,987
13.00 01300	NURSING ADMINISTRATION	5,047	6,004	1,779,593	0	2,429,986
14.00 01400	CENTRAL SERVICES & SUPPLY	5,621	34,006	339,577	0	798,100
15.00 01500	PHARMACY	4,763	51,406	2,276,646	0	9,786,085
16.00 01600	MEDICAL RECORDS & LIBRARY	4,938	8,271	1,286,577	0	2,133,784
17.00 01700	SOCIAL SERVICE	200	0	1,229,283	0	1,772,022
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,554,556	0	1,857,281
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,798	1,584	0	0	381,899
23.00 02300	CLINICAL PASTORAL EDUCATION	3,114	0	232,338	0	369,870
23.01 02301	EMS PROGRAM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	101,266	715,655	10,254,134	0	16,552,155
31.00 03100	INTENSIVE CARE UNIT	26,679	298,992	3,512,079	0	5,670,583
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00 04100	SUBPROVIDER - IRF	11,102	6,941	899,710	0	1,372,489
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	5,196	0	2,188,546	0	2,934,944
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	28,709	713,030	3,946,972	0	7,407,841
51.00 05100	RECOVERY ROOM	2,493	17,620	602,190	0	809,304
53.00 05300	ANESTHESIOLOGY	520	50,074	38,698	0	164,610
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,963	884,430	2,289,689	0	4,364,634
57.00 05700	CT SCAN	4,819	168,152	421,014	0	907,193
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	15,221	127,071	1,945,729	0	3,549,260
65.00 06500	RESPIRATORY THERAPY	4,854	39,052	863,358	0	1,219,374
66.00 06600	PHYSICAL THERAPY	13,738	27,981	1,300,292	0	2,046,184
67.00 06700	OCCUPATIONAL THERAPY	1,298	0	345,083	0	478,694
68.00 06800	SPEECH PATHOLOGY	996	0	230,733	0	324,393
69.00 06900	ELECTROCARDIOLOGY	10,476	882,581	1,704,446	0	3,694,041
70.00 07000	ELECTROENCEPHALOGRAPHY	973	6,806	77,128	0	193,599
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,654,797
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	9,774,400
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	2,705	9,034	342,676	0	484,210
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	5,052	1,431	550,305	0	871,764
90.01 09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0
90.03 09002	PSYCH OUTPATIENT	0	0	0	0	0
90.04 09003	WOUND CARE CLINIC	3,751	814	512,896	0	1,291,863
91.00 09100	EMERGENCY	16,583	105,441	3,272,179	0	4,732,614
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	511,612	4,955,422	55,310,701	-22,615,560	110,478,512
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,612	7,589	399,322	0	1,273,478
190.01 19001	OTHER NONREIMBURSABLE	13,123	3,685	474,868	0	2,548,136
190.13 19007	EUREKA	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6,073,992	5,886,536	11,209,522		22,615,560	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.324743	1.185202	0.199511		0.197861	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			44,729		1,359,510	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000796		0.011894	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	348,934				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	996,976			8.00
9.00	00900	HOUSEKEEPING	7,606	68,440	66,306		9.00
10.00	01000	DIETARY	3,590	2,344	0	97,323	10.00
11.00	01100	CAFETERIA	6,293	1,818	1,863	0	71,419
13.00	01300	NURSING ADMINISTRATION	5,047	0	0	0	2,349
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	0	1,783	0	1,005
15.00	01500	PHARMACY	4,763	0	1,820	0	2,533
16.00	01600	MEDICAL RECORDS & LIBRARY	4,938	0	69	0	2,451
17.00	01700	SOCIAL SERVICE	200	0	208	0	1,590
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,798	0	228	0	2,544
23.00	02300	CLINICAL PASTORAL EDUCATION	3,114	0	208	0	773
23.01	02301	EMS PROGRAM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,266	332,439	28,080	67,271	16,582
31.00	03100	INTENSIVE CARE UNIT	26,679	115,783	1,077	21,866	5,773
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	11,102	25,295	1,040	8,186	1,597
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	5,196	4,841	1,060	0	3,455
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,709	141,558	9,568	0	5,935
51.00	05100	RECOVERY ROOM	2,493	13,934	1,040	0	758
53.00	05300	ANESTHESIOLOGY	520	0	0	0	89
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,963	46,471	2,080	0	3,668
57.00	05700	CT SCAN	4,819	20,249	0	0	608
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	15,221	454	2,080	0	3,833
65.00	06500	RESPIRATORY THERAPY	4,854	0	208	0	1,601
66.00	06600	PHYSICAL THERAPY	13,738	21,731	1,038	0	1,710
67.00	06700	OCCUPATIONAL THERAPY	1,298	163	56	0	474
68.00	06800	SPEECH PATHOLOGY	996	0	20	0	296
69.00	06900	ELECTROCARDIOLOGY	10,476	27,158	1,248	0	1,938
70.00	07000	ELECTROENCEPHALOGRAPHY	973	1,872	0	0	106
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,894	0	0	0
76.97	07697	CARDIAC REHABILITATION	2,705	685	0	0	562
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,052	460	518	0	824
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0
90.04	09003	WOUND CARE CLINIC	3,751	10,722	1,395	0	749
91.00	09100	EMERGENCY	16,583	158,665	8,320	0	5,278
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	324,199	996,976	65,007	97,323	69,081
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,612	0	1,218	0	1,368
190.01	19001	OTHER NONREIMBURSABLE	13,123	0	81	0	970
190.13	19007	EUREKA	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	9,186,093	958,698	2,929,906	1,654,905	1,055,886	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26.326162	0.961606	44.187645	17.004254	14.784385	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,682,553	231,222	193,446	147,418	115,818	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.821981	0.231923	2.917474	1.514729	1.621669	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	51,368					13.00
14.00	01400	89	1,048,296				14.00
15.00	01500	105	11,500	7,915,684			15.00
16.00	01600	388	1,844	0	3,854,964		16.00
17.00	01700	1,651	0	0	0	6,722	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	4,936	0	0	0	22.00
23.00	02300	0	11,333	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,314	125,018	4,773	67,446	2,372	30.00
31.00	03100	7,623	42,337	2,437	27,044	1,164	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	1,915	4,984	12	24,638	600	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	4,237	28,566	0	36,850	20	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,452	124,868	85,000	559,189	0	50.00
51.00	05100	967	451	2,475	31,400	0	51.00
53.00	05300	97	12,338	36,876	73,673	0	53.00
54.00	05400	13	33,770	4,253	411,221	0	54.00
57.00	05700	0	4,060	22,798	452,062	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	42	37,923	343	445,913	0	60.00
65.00	06500	100	10,848	1,961	23,557	0	65.00
66.00	06600	101	5,352	0	46,615	0	66.00
67.00	06700	0	0	0	7,285	0	67.00
68.00	06800	0	252	0	3,100	0	68.00
69.00	06900	493	29,369	82,642	254,656	0	69.00
70.00	07000	0	25	0	8,897	0	70.00
71.00	07100	0	0	0	483	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	6,275,769	468,150	0	73.00
76.97	07697	0	2,573	0	8,212	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	180	4,829	31	0	32	90.00
90.01	09001	0	0	0	0	0	90.01
90.03	09002	0	0	0	0	0	90.03
90.04	09003	218	5,452	0	94,397	0	90.04
91.00	09100	6,347	42,792	123,781	810,176	2,534	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	0	0	0	116.00
118.00		51,332	545,420	6,643,151	3,854,964	6,722	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	481,411	0	0	0	190.00
190.01	19001	36	21,465	1,272,533	0	0	190.01
190.13	19007	0	0	0	0	0	190.13
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3,078,382	1,202,971	11,985,122	2,750,630	2,259,540	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	59.928010	1.147549	1.514098	0.713529	336.141029	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	122,737	147,872	267,332	121,302	32,414	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.389367	0.141059	0.033772	0.031466	4.822077	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	100				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		100			22.00
23.00 02300 CLINICAL PASTORAL EDUCATION			4,062		23.00
23.01 02301 EMS PROGRAM				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	100	100	1,900	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	845	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	106	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	776	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	3	0	54.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	76	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	313	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100	100	4,019	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001 OTHER NONREIMBURSABLE	0	0	43	0	190.01
190.13 19007 EUREKA	0	0	0	0	190.13
191.00 19100 RESEARCH	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description	INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
	21.00	22.00				
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,224,764	584,473	558,657	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22,247.640000	5,844.730000	137.532496	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23,328	94,665	58,325	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	233.280000	946.650000	14.358690	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 8:22 am
			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		27,917,487	0	27,917,487
31.00	03100 INTENSIVE CARE UNIT		9,146,904	0	9,146,904
40.00	04000 SUBPROVIDER - I/PF		0	0	0
41.00	04100 SUBPROVIDER - I/RP		2,523,753	0	2,523,753
42.00	04200 SUBPROVIDER		0	0	0
43.00	04300 NURSERY		4,074,733	0	4,074,733
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		11,440,386	0	11,440,386
51.00	05100 RECOVERY ROOM		1,190,246	0	1,190,246
53.00	05300 ANESTHESIOLOGY		340,559	0	340,559
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,126,445	0	6,126,445
57.00	05700 CT SCAN		1,603,754	0	1,603,754
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0
59.00	05900 CARDIAC CATHETERIZATION		0	0	0
60.00	06000 LABORATORY		5,165,974	0	5,165,974
65.00	06500 RESPIRATORY THERAPY	0	1,659,509	0	1,659,509
66.00	06600 PHYSICAL THERAPY	0	2,950,214	0	2,950,214
67.00	06700 OCCUPATIONAL THERAPY	0	622,418	0	622,418
68.00	06800 SPEECH PATHOLOGY	0	422,560	0	422,560
69.00	06900 ELECTROCARDIOLOGY		5,191,185	0	5,191,185
70.00	07000 ELECTROENCEPHALOGRAPHY		267,264	0	267,264
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11,565,450	0	11,565,450
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		11,708,373	0	11,708,373
73.00	07300 DRUGS CHARGED TO PATIENTS		9,837,991	0	9,837,991
76.97	07697 CARDIAC REHABILITATION		669,009	0	669,009
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		1,239,898	0	1,239,898
90.01	09001 BASIC DIAGNOSTIC TESTING		0	0	0
90.03	09002 PSYCH OUTPATIENT		0	0	0
90.04	09003 WOUND CARE CLINIC		1,815,922	0	1,815,922
91.00	09100 EMERGENCY		8,793,624	0	8,793,624
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,505,329	0	3,505,329
93.00	04040 OTHER OUTPATIENT SERVICES		0	0	0
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0	0
101.00	10100 HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0	0
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0
111.00	11100 ISLET ACQUISITION	0	0	0	0
113.00	11300 INTEREST EXPENSE	0	0	0	0
116.00	11600 HOSPICE	0	0	0	0
200.00	Subtotal (see instructions)	0	129,778,987	0	129,778,987
201.00	Less Observation Beds	0	3,505,329	0	3,505,329
202.00	Total (see instructions)	0	126,273,658	0	126,273,658

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/24/2017 8:22 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	40,886,127		40,886,127				30.00
31.00	03100	INTENSIVE CARE UNIT	13,967,461		13,967,461				31.00
40.00	04000	SUBPROVIDER - I PF	0		0				40.00
41.00	04100	SUBPROVIDER - I RF	3,158,645		3,158,645				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	5,793,948		5,793,948				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	23,019,151	26,346,514	49,365,665	0.231748	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,537,131	2,066,635	3,603,766	0.330278	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	4,460,244	4,542,415	9,002,659	0.037829	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,697,355	28,044,332	35,741,687	0.171409	0.000000		54.00
57.00	05700	CT SCAN	10,410,231	29,401,399	39,811,630	0.040284	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	21,744,831	28,186,791	49,931,622	0.103461	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	3,739,153	685,608	4,424,761	0.375051	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,659,776	2,997,149	5,656,925	0.521523	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,749,113	283,575	2,032,688	0.306204	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	625,510	156,603	782,113	0.540280	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	10,088,444	13,616,813	23,705,257	0.218989	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	304,300	757,381	1,061,681	0.251737	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,089,124	4,084,679	10,173,803	1.136787	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,878,083	8,644,669	28,522,752	0.410492	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,006,403	25,691,369	70,697,772	0.139156	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	19,111	645,953	665,064	1.005932	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	118	1,110,867	1,110,985	1.116035	0.000000		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000		90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0.000000	0.000000		90.03
90.04	09003	WOUND CARE CLINIC	349,654	6,529,661	6,879,315	0.263968	0.000000		90.04
91.00	09100	EMERGENCY	6,782,697	23,974,659	30,757,356	0.285903	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,087,903	3,912,481	5,000,384	0.701012	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0				99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	0	0				116.00
200.00		Subtotal (see instructions)	231,054,513	211,679,553	442,734,066				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	231,054,513	211,679,553	442,734,066				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 8:22 am
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.231748		50.00
51.00	05100	RECOVERY ROOM	0.330278		51.00
53.00	05300	ANESTHESIOLOGY	0.037829		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171409		54.00
57.00	05700	CT SCAN	0.040284		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.103461		60.00
65.00	06500	RESPIRATORY THERAPY	0.375051		65.00
66.00	06600	PHYSICAL THERAPY	0.521523		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306204		67.00
68.00	06800	SPEECH PATHOLOGY	0.540280		68.00
69.00	06900	ELECTROCARDIOLOGY	0.218989		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251737		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410492		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.139156		73.00
76.97	07697	CARDIAC REHABILITATION	1.005932		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.116035		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000		90.01
90.03	09002	PSYCH OUTPATIENT	0.000000		90.03
90.04	09003	WOUND CARE CLINIC	0.263968		90.04
91.00	09100	EMERGENCY	0.285903		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.701012		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0127

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 8:22 am

		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		27,917,487	0	27,917,487	30.00
31.00	03100 INTENSIVE CARE UNIT		9,146,904	0	9,146,904	31.00
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RP		2,523,753	0	2,523,753	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		4,074,733	0	4,074,733	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		11,440,386	0	11,440,386	50.00
51.00	05100 RECOVERY ROOM		1,190,246	0	1,190,246	51.00
53.00	05300 ANESTHESIOLOGY		340,559	0	340,559	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,126,445	0	6,126,445	54.00
57.00	05700 CT SCAN		1,603,754	0	1,603,754	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		5,165,974	0	5,165,974	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,659,509	0	1,659,509	65.00
66.00	06600 PHYSICAL THERAPY	0	2,950,214	0	2,950,214	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	622,418	0	622,418	67.00
68.00	06800 SPEECH PATHOLOGY	0	422,560	0	422,560	68.00
69.00	06900 ELECTROCARDIOLOGY		5,191,185	0	5,191,185	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		267,264	0	267,264	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11,565,450	0	11,565,450	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		11,708,373	0	11,708,373	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		9,837,991	0	9,837,991	73.00
76.97	07697 CARDIAC REHABILITATION		669,009	0	669,009	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		1,239,898	0	1,239,898	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING		0	0	0	90.01
90.03	09002 PSYCH OUTPATIENT		0	0	0	90.03
90.04	09003 WOUND CARE CLINIC		1,815,922	0	1,815,922	90.04
91.00	09100 EMERGENCY		8,793,624	0	8,793,624	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,505,329	0	3,505,329	92.00
93.00	04040 OTHER OUTPATIENT SERVICES		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600 HOSPICE	0	0	0	0	116.00
200.00	Subtotal (see instructions)		129,778,987	0	129,778,987	200.00
201.00	Less Observation Beds		3,505,329	0	3,505,329	201.00
202.00	Total (see instructions)		126,273,658	0	126,273,658	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/24/2017 8:22 am	
			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	40,886,127		40,886,127			30.00
31.00	03100	INTENSIVE CARE UNIT	13,967,461		13,967,461			31.00
40.00	04000	SUBPROVIDER - I PF	0		0			40.00
41.00	04100	SUBPROVIDER - I RF	3,158,645		3,158,645			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	5,793,948		5,793,948			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,019,151	26,346,514	49,365,665	0.231748	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,537,131	2,066,635	3,603,766	0.330278	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,460,244	4,542,415	9,002,659	0.037829	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,697,355	28,044,332	35,741,687	0.171409	0.000000	54.00
57.00	05700	CT SCAN	10,410,231	29,401,399	39,811,630	0.040284	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	21,744,831	28,186,791	49,931,622	0.103461	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,739,153	685,608	4,424,761	0.375051	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,659,776	2,997,149	5,656,925	0.521523	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,749,113	283,575	2,032,688	0.306204	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	625,510	156,603	782,113	0.540280	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,088,444	13,616,813	23,705,257	0.218989	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	304,300	757,381	1,061,681	0.251737	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,089,124	4,084,679	10,173,803	1.136787	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,878,083	8,644,669	28,522,752	0.410492	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,006,403	25,691,369	70,697,772	0.139156	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	19,111	645,953	665,064	1.005932	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	118	1,110,867	1,110,985	1.116035	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0.000000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	349,654	6,529,661	6,879,315	0.263968	0.000000	90.04
91.00	09100	EMERGENCY	6,782,697	23,974,659	30,757,356	0.285903	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,087,903	3,912,481	5,000,384	0.701012	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	231,054,513	211,679,553	442,734,066			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	231,054,513	211,679,553	442,734,066			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000			90.01
90.03	09002	PSYCH OUTPATIENT	0.000000			90.03
90.04	09003	WOUND CARE CLINIC	0.000000			90.04
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/24/2017 8:22 am
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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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,205,016	0	3,205,016	23,200	138.15	30.00
31.00	INTENSIVE CARE UNIT	1,033,545		1,033,545	7,560	136.71	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	267,205	0	267,205	3,002	89.01	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	145,776		145,776	4,103	35.53	43.00
200.00	Total (lines 30-199)	4,651,542		4,651,542	37,865		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	7,641	1,055,604				
31.00	INTENSIVE CARE UNIT	3,407	465,771				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	1,949	173,480				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	12,997	1,694,855				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/24/2017 8:22 am
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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	1,602,999	49,365,665	0.032472	9,410,773	305,587	50.00
51.00	05100	RECOVERY ROOM	82,184	3,603,766	0.022805	647,997	14,778	51.00
53.00	05300	ANESTHESIOLOGY	75,412	9,002,659	0.008377	1,644,486	13,776	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,508,602	35,741,687	0.042208	3,543,451	149,562	54.00
57.00	05700	CT SCAN	327,947	39,811,630	0.008237	5,002,041	41,202	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	527,916	49,931,622	0.010573	9,690,878	102,462	60.00
65.00	06500	RESPIRATORY THERAPY	145,630	4,424,761	0.032913	2,691,683	88,591	65.00
66.00	06600	PHYSICAL THERAPY	439,235	5,656,925	0.077646	882,555	68,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,127	2,032,688	0.013837	406,451	5,624	67.00
68.00	06800	SPEECH PATHOLOGY	20,796	782,113	0.026590	105,981	2,818	68.00
69.00	06900	ELECTROCARDIOLOGY	1,289,692	23,705,257	0.054405	4,594,793	249,980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,031	1,061,681	0.025461	157,772	4,017	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,849	10,173,803	0.011289	1,542,396	17,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	116,257	28,522,752	0.004076	9,075,411	36,991	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,119	70,697,772	0.003213	17,238,118	55,386	73.00
76.97	07697	CARDIAC REHABILITATION	62,106	665,064	0.093383	6,325	591	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	98,297	1,110,985	0.088477	118	10	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	89,336	6,879,315	0.012986	144,754	1,880	90.04
91.00	09100	EMERGENCY	584,352	30,757,356	0.018999	2,943,916	55,931	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	402,422	5,000,384	0.080478	467,531	37,626	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	7,770,309	378,927,885		70,197,430	1,252,751	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part III Date/Time Prepared: 5/24/2017 8:22 am
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Title XVIII			Hospital		PPS		
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	261,312	0	261,312	30.00
31.00	03100	INTENSIVE CARE UNIT	0	116,215	0	116,215	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	14,578	0	14,578	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	392,105	0	392,105	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	23,200	11.26	7,641	86,038	30.00
31.00	03100	INTENSIVE CARE UNIT	7,560	15.37	3,407	52,366	31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,002	4.86	1,949	9,472	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	4,103	0.00	0	0	43.00
200.00		Total (lines 30-199)	37,865		12,997	147,876	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 8:22 am
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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	106,725	0	0	106,725	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	413	0	0	413	54.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	10,452	0	0	10,452	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0	0	0	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0	0	0	0	90.03
90.04 09003 WOUND CARE CLINIC	0	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	43,048	0	0	43,048	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	32,810	0	0	32,810	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	193,448	0	0	193,448	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 8:22 am
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Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	106,725	49,365,665	0.002162	0.002162	9,410,773	50.00
51.00	05100	RECOVERY ROOM	0	3,603,766	0.000000	0.000000	647,997	51.00
53.00	05300	ANESTHESIOLOGY	0	9,002,659	0.000000	0.000000	1,644,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413	35,741,687	0.000012	0.000012	3,543,451	54.00
57.00	05700	CT SCAN	0	39,811,630	0.000000	0.000000	5,002,041	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	49,931,622	0.000000	0.000000	9,690,878	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,424,761	0.000000	0.000000	2,691,683	65.00
66.00	06600	PHYSICAL THERAPY	0	5,656,925	0.000000	0.000000	882,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,032,688	0.000000	0.000000	406,451	67.00
68.00	06800	SPEECH PATHOLOGY	0	782,113	0.000000	0.000000	105,981	68.00
69.00	06900	ELECTROCARDIOLOGY	10,452	23,705,257	0.000441	0.000441	4,594,793	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,061,681	0.000000	0.000000	157,772	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,173,803	0.000000	0.000000	1,542,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	28,522,752	0.000000	0.000000	9,075,411	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,697,772	0.000000	0.000000	17,238,118	73.00
76.97	07697	CARDIAC REHABILITATION	0	665,064	0.000000	0.000000	6,325	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,110,985	0.000000	0.000000	118	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0.000000	0	90.03
90.04	09003	WOUND CARE CLINIC	0	6,879,315	0.000000	0.000000	144,754	90.04
91.00	09100	EMERGENCY	43,048	30,757,356	0.001400	0.001400	2,943,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	32,810	5,000,384	0.006561	0.006561	467,531	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	193,448	378,927,885			70,197,430	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 8:22 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	20,346	4,928,359	10,655	50.00
51.00	05100 RECOVERY ROOM	0	344,089	0	51.00
53.00	05300 ANESTHESIOLOGY	0	858,484	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	43	5,704,991	68	54.00
57.00	05700 CT SCAN	0	6,859,312	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	4,940,339	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	133,953	0	65.00
66.00	06600 PHYSICAL THERAPY	0	44,167	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	19,919	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,531	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,026	6,001,758	2,647	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	101,600	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,135,021	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	3,450,353	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,505,428	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	238,267	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	16,267	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0	2,930,077	0	90.04
91.00	09100 EMERGENCY	4,121	3,764,405	5,270	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,067	1,276,972	8,378	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	0	93.00
200.00	Total (lines 50-199)	29,603	48,257,292	27,018	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.231748	4,928,359	0	0	1,142,137	50.00
51.00	05100	RECOVERY ROOM	0.330278	344,089	0	0	113,645	51.00
53.00	05300	ANESTHESIOLOGY	0.037829	858,484	0	0	32,476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171409	5,704,991	0	0	977,887	54.00
57.00	05700	CT SCAN	0.040284	6,859,312	0	0	276,321	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.103461	4,940,339	0	1,145	511,132	60.00
65.00	06500	RESPIRATORY THERAPY	0.375051	133,953	0	0	50,239	65.00
66.00	06600	PHYSICAL THERAPY	0.521523	44,167	0	0	23,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306204	19,919	0	0	6,099	67.00
68.00	06800	SPEECH PATHOLOGY	0.540280	3,531	0	0	1,908	68.00
69.00	06900	ELECTROCARDIOLOGY	0.218989	6,001,758	0	0	1,314,319	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251737	101,600	0	0	25,576	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787	1,135,021	0	0	1,290,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410492	3,450,353	0	0	1,416,342	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.139156	5,505,428	0	189,264	766,113	73.00
76.97	07697	CARDIAC REHABILITATION	1.005932	238,267	0	0	239,680	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1.116035	16,267	0	0	18,155	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.263968	2,930,077	0	0	773,447	90.04
91.00	09100	EMERGENCY	0.285903	3,764,405	0	0	1,076,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.701012	1,276,972	0	0	895,173	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		48,257,292	0	190,409	10,950,215	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		48,257,292	0	190,409	10,950,215	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 8:22 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	118		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	26,337		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03 09002 PSYCH OUTPATIENT	0	0		90.03
90.04 09003 WOUND CARE CLINIC	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0		93.00
200.00 Subtotal (see instructions)	0	26,455		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	26,455		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/24/2017 8:22 am	
			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	1,602,999	49,365,665	0.032472	1,426	46	50.00
51.00	05100	RECOVERY ROOM	82,184	3,603,766	0.022805	0	0	51.00
53.00	05300	ANESTHESIOLOGY	75,412	9,002,659	0.008377	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,508,602	35,741,687	0.042208	44,324	1,871	54.00
57.00	05700	CT SCAN	327,947	39,811,630	0.008237	49,290	406	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	527,916	49,931,622	0.010573	161,211	1,704	60.00
65.00	06500	RESPIRATORY THERAPY	145,630	4,424,761	0.032913	45,879	1,510	65.00
66.00	06600	PHYSICAL THERAPY	439,235	5,656,925	0.077646	655,146	50,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,127	2,032,688	0.013837	662,707	9,170	67.00
68.00	06800	SPEECH PATHOLOGY	20,796	782,113	0.026590	258,647	6,877	68.00
69.00	06900	ELECTROCARDIOLOGY	1,289,692	23,705,257	0.054405	9,756	531	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,031	1,061,681	0.025461	5,792	147	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,849	10,173,803	0.011289	242,719	2,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	116,257	28,522,752	0.004076	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,119	70,697,772	0.003213	1,195,641	3,842	73.00
76.97	07697	CARDIAC REHABILITATION	62,106	665,064	0.093383	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	98,297	1,110,985	0.088477	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	89,336	6,879,315	0.012986	16,132	209	90.04
91.00	09100	EMERGENCY	584,352	30,757,356	0.018999	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,000,384	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	7,367,887	378,927,885		3,348,670	79,922	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 8:22 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	106,725	0	106,725	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	413	0	413	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	10,452	0	10,452	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	43,048	0	43,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	160,638	0	160,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 8:22 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	106,725	49,365,665	0.002162	0.002162	1,426	50.00
51.00 05100 RECOVERY ROOM	0	3,603,766	0.000000	0.000000	0	51.00
53.00 05300 ANESTHESIOLOGY	0	9,002,659	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	413	35,741,687	0.000012	0.000012	44,324	54.00
57.00 05700 CT SCAN	0	39,811,630	0.000000	0.000000	49,290	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	49,931,622	0.000000	0.000000	161,211	60.00
65.00 06500 RESPIRATORY THERAPY	0	4,424,761	0.000000	0.000000	45,879	65.00
66.00 06600 PHYSICAL THERAPY	0	5,656,925	0.000000	0.000000	655,146	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,032,688	0.000000	0.000000	662,707	67.00
68.00 06800 SPEECH PATHOLOGY	0	782,113	0.000000	0.000000	258,647	68.00
69.00 06900 ELECTROCARDIOLOGY	10,452	23,705,257	0.000441	0.000441	9,756	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,061,681	0.000000	0.000000	5,792	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,173,803	0.000000	0.000000	242,719	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	28,522,752	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	70,697,772	0.000000	0.000000	1,195,641	73.00
76.97 07697 CARDIAC REHABILITATION	0	665,064	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	1,110,985	0.000000	0.000000	0	90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0	0.000000	0.000000	0	90.01
90.03 09002 PSYCH OUTPATIENT	0	0	0.000000	0.000000	0	90.03
90.04 09003 WOUND CARE CLINIC	0	6,879,315	0.000000	0.000000	16,132	90.04
91.00 09100 EMERGENCY	43,048	30,757,356	0.001400	0.001400	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5,000,384	0.000000	0.000000	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	160,638	378,927,885			3,348,670	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 8:22 am
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	3	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	4	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0	0	0	93.00
200.00	Total (lines 50-199)	8	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 8:22 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.231748	0	1,218,310	0	0	50.00
51.00	05100 RECOVERY ROOM	0.330278	0	120,697	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.037829	0	238,281	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171409	0	1,298,986	0	0	54.00
57.00	05700 CT SCAN	0.040284	0	1,158,527	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.103461	0	1,431,477	1,145	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.375051	0	36,500	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.521523	0	108,949	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.306204	0	23,116	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.540280	0	8,122	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.218989	0	329,392	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251737	0	28,277	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787	0	194,381	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.410492	0	341,423	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.139156	0	1,269,462	189,264	0	73.00
76.97	07697 CARDIAC REHABILITATION	1.005932	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1.116035	0	10,614	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.263968	0	68,401	0	0	90.04
91.00	09100 EMERGENCY	0.285903	0	2,247,752	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.701012	0	181,968	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00	Subtotal (see instructions)		0	10,314,635	190,409	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	10,314,635	190,409	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 8:22 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	282,341	0		50.00
51.00 05100 RECOVERY ROOM	39,864	0		51.00
53.00 05300 ANESTHESIOLOGY	9,014	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	222,658	0		54.00
57.00 05700 CT SCAN	46,670	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	148,102	118		60.00
65.00 06500 RESPIRATORY THERAPY	13,689	0		65.00
66.00 06600 PHYSICAL THERAPY	56,819	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	7,078	0		67.00
68.00 06800 SPEECH PATHOLOGY	4,388	0		68.00
69.00 06900 ELECTROCARDIOLOGY	72,133	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	7,118	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	220,970	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	140,151	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	176,653	26,337		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	11,846	0		90.00
90.01 09001 BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03 09002 PSYCH OUTPATIENT	0	0		90.03
90.04 09003 WOUND CARE CLINIC	18,056	0		90.04
91.00 09100 EMERGENCY	642,639	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	127,562	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICES	0	0		93.00
200.00 Subtotal (see instructions)	2,247,751	26,455		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,247,751	26,455		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/24/2017 8:22 am
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)		23,200	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,200	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)		20,287	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)		7,641	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,917,487	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27,917,487	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,917,487	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,203.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,194,721	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,194,721	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/24/2017 8:22 am	
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	9,146,904	7,560	1,209.91	3,407	4,122,163		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)					16,057,770		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,374,654		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,659,779		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,282,354		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,942,133		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					26,432,521		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,913		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,203.34		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,505,329		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,205,016	27,917,487	0.114803	3,505,329	402,422	90.00
91.00	Nursing School cost	0	27,917,487	0.000000	3,505,329	0	91.00
92.00	Allied health cost	261,312	27,917,487	0.009360	3,505,329	32,810	92.00
93.00	All other Medical Education	0	27,917,487	0.000000	3,505,329	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 8:22 am
		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)			3,002 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,002 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,002 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)			1,949 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,523,753 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,523,753 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,523,753 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)			840.69 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,638,505 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)			1,638,505 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 8:22 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,178,293		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,816,798		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)					182,952		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					79,930		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					262,882		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,553,916		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: 14-0127 Component CCN: 14-T127		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 8:22 am	
		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	267,205	2,523,753	0.105876	0	0	90.00
91.00	Nursing School cost	0	2,523,753	0.000000	0	0	91.00
92.00	Allied health cost	14,578	2,523,753	0.005776	0	0	92.00
93.00	All other Medical Education	0	2,523,753	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/24/2017 8:22 am
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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		12,777,384		30.00
31.00	03100 INTENSIVE CARE UNIT		5,726,002		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.231748	9,410,773	2,180,928	50.00
51.00	05100 RECOVERY ROOM	0.330278	647,997	214,019	51.00
53.00	05300 ANESTHESIOLOGY	0.037829	1,644,486	62,209	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171409	3,543,451	607,379	54.00
57.00	05700 CT SCAN	0.040284	5,002,041	201,502	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.103461	9,690,878	1,002,628	60.00
65.00	06500 RESPIRATORY THERAPY	0.375051	2,691,683	1,009,518	65.00
66.00	06600 PHYSICAL THERAPY	0.521523	882,555	460,273	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.306204	406,451	124,457	67.00
68.00	06800 SPEECH PATHOLOGY	0.540280	105,981	57,259	68.00
69.00	06900 ELECTROCARDIOLOGY	0.218989	4,594,793	1,006,209	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251737	157,772	39,717	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787	1,542,396	1,753,376	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.410492	9,075,411	3,725,384	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.139156	17,238,118	2,398,788	73.00
76.97	07697 CARDIAC REHABILITATION	1.005932	6,325	6,363	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.116035	118	132	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0.000000	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.263968	144,754	38,210	90.04
91.00	09100 EMERGENCY	0.285903	2,943,916	841,674	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.701012	467,531	327,745	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		70,197,430	16,057,770	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		70,197,430		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/24/2017 8:22 am	
		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
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		2,052,940	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.231748	1,426	50.00
51.00	05100	RECOVERY ROOM	0.330278	0	51.00
53.00	05300	ANESTHESIOLOGY	0.037829	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171409	44,324	54.00
57.00	05700	CT SCAN	0.040284	49,290	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.103461	161,211	60.00
65.00	06500	RESPIRATORY THERAPY	0.375051	45,879	65.00
66.00	06600	PHYSICAL THERAPY	0.521523	655,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306204	662,707	67.00
68.00	06800	SPEECH PATHOLOGY	0.540280	258,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0.218989	9,756	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251737	5,792	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787	242,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410492	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.139156	1,195,641	73.00
76.97	07697	CARDIAC REHABILITATION	1.005932	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.116035	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	90.03
90.04	09003	WOUND CARE CLINIC	0.263968	16,132	90.04
91.00	09100	EMERGENCY	0.285903	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.701012	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		3,348,670	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)		3,348,670	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/24/2017 8:22 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,616,877		30.00
31.00	03100 INTENSIVE CARE UNIT		486,832		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		1,311,409		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.231748	356,257	82,562	50.00
51.00	05100 RECOVERY ROOM	0.330278	24,406	8,061	51.00
53.00	05300 ANESTHESIOLOGY	0.037829	90,266	3,415	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171409	291,351	49,940	54.00
57.00	05700 CT SCAN	0.040284	417,010	16,799	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.103461	882,500	91,304	60.00
65.00	06500 RESPIRATORY THERAPY	0.375051	154,667	58,008	65.00
66.00	06600 PHYSICAL THERAPY	0.521523	17,004	8,868	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.306204	9,764	2,990	67.00
68.00	06800 SPEECH PATHOLOGY	0.540280	3,911	2,113	68.00
69.00	06900 ELECTROCARDIOLOGY	0.218989	316,321	69,271	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.251737	10,147	2,554	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787	130,905	148,811	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.410492	57,533	23,617	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.139156	1,375,346	191,388	73.00
76.97	07697 CARDIAC REHABILITATION	1.005932	1,028	1,034	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.116035	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0.000000	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.263968	3,899	1,029	90.04
91.00	09100 EMERGENCY	0.285903	248,231	70,970	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.701012	50,724	35,558	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		4,441,270	868,292	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,441,270		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/24/2017 8:22 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		86,486	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.231748	0	50.00
51.00	05100	RECOVERY ROOM	0.330278	0	51.00
53.00	05300	ANESTHESIOLOGY	0.037829	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171409	3,010	54.00
57.00	05700	CT SCAN	0.040284	3,792	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.103461	9,839	60.00
65.00	06500	RESPIRATORY THERAPY	0.375051	0	65.00
66.00	06600	PHYSICAL THERAPY	0.521523	22,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306204	24,970	67.00
68.00	06800	SPEECH PATHOLOGY	0.540280	17,954	68.00
69.00	06900	ELECTROCARDIOLOGY	0.218989	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251737	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136787	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410492	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.139156	28,598	73.00
76.97	07697	CARDIAC REHABILITATION	1.005932	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.116035	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	90.03
90.04	09003	WOUND CARE CLINIC	0.263968	210	90.04
91.00	09100	EMERGENCY	0.285903	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.701012	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		111,124	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)		111,124	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		15,447,703	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,485,158	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)		496,224	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		6,910,570	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		197.54	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		13.60	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		1.03	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)		12.57	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		16.26	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)		12.57	12.00
13.00	Total allowable FTE count for the prior year.		12.57	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.		12.57	14.00
15.00	Sum of lines 12 through 14 divided by 3.		12.57	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		12.57	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.063633	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.063501	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.063501	21.00
22.00	IME payment adjustment (see instructions)		713,497	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		235,547	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		3.69	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)		713,497	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		235,547	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.46	31.00
32.00	Sum of lines 30 and 31		26.68	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.23	33.00
34.00	Disproportionate share adjustment (see instructions)		587,690	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000180815	0.000186236	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,158,327	1,113,223	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	867,163	280,593	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,147,756		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)	23,878,028		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)		24,113,575	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,908,354	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).		461,214	52.00
53.00	Nursing and Allied Health Managed Care payment		148,726	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).		138,404	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		29,603	58.00
59.00	Total (sum of amounts on lines 49 through 58)		26,799,876	59.00
60.00	Primary payer payments		6,361	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		26,793,515	61.00
62.00	Deductibles billed to program beneficiaries		2,550,609	62.00
63.00	Coinurance billed to program beneficiaries		12,880	63.00
64.00	Allowable bad debts (see instructions)		411,074	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		267,198	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		215,995	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		24,497,224	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 PER PS&R		-726	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)		108,806	70.93
70.94	HRR adjustment amount (see instructions)		-52,276	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 8:22 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		24,553,028		71.00
71.01	Sequestration adjustment (see instructions)		491,061		71.01
72.00	Interim payments		23,779,049		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)		282,918		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		93,018		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		26,455	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,923,197	2.00
3.00	PPS payments		8,926,287	3.00
4.00	Outlier payment (see instructions)		47,824	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.757	5.00
6.00	Line 2 times line 5		8,268,860	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		27,018	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		26,455	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		190,409	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)		190,409	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)		190,409	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		163,954	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)		26,455	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)		9,001,129	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,700,964	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)		7,326,620	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		157,285	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)		7,483,905	30.00
31.00	Primary payer payments		777	31.00
32.00	Subtotal (line 30 minus line 31)		7,483,128	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)		361,050	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		234,683	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		209,966	36.00
37.00	Subtotal (see instructions)		7,717,811	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS PER PS&R		-45	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)		7,717,766	40.00
40.01	Sequestration adjustment (see instructions)		154,355	40.01
41.00	Interim payments		7,475,759	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		87,652	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: 14-0127

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2017 8:22 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,867,611		7,469,682	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	08/18/2016	9,481	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	08/18/2016	57,528	12/20/2016	3,404	3.50	
3.51		12/20/2016	31,034		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)		-88,562		6,077	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,779,049		7,475,759	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		282,918		87,652	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		24,061,967		7,563,411	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2016 To 12/31/2016		Worksheet E-1 Part I Date/Time Prepared: 5/24/2017 8:22 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					0	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		2,823,511			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	08/15/2016	14,420			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)		-14,420			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)		2,809,091			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		33,704			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		2,842,795			0	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/24/2017 8:22 am
		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		8,012	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		11,048	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3,290	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		27,847	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		442,734,066	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		12,482,513	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)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,781,122 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0160 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			99,008 3.00
4.00	Outlier Payments			51,773 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)			8.202186 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)			2,931,903 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)			2,931,903 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,931,903 19.00
20.00	Deductibles			28,336 20.00
21.00	Subtotal (line 19 minus line 20)			2,903,567 21.00
22.00	Coinsurance			12,236 22.00
23.00	Subtotal (line 21 minus line 22)			2,891,331 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)			2,891,331 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)			9,480 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)			2,900,811 32.00
32.01	Sequestration adjustment (see instructions)			58,016 32.01
33.00	Interim payments			2,809,091 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)			33,704 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			51,773 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/24/2017 8:22 am	
		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.			13.60	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)			1.03	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)			12.57	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			16.26	6.00
7.00	Enter the lesser of line 5 or line 6			12.57	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.	6.41	9.85	16.26	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.	4.96	7.61	12.57	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	4.96	7.61		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.23	7.34		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.33	6.81		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.17	7.25		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	5.17	7.25		17.00
18.00	Per resident amount	98,308.98	98,308.98		18.00
19.00	Approved amount for resident costs	508,257	712,740	1,220,997	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			3.69	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,220,997	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	12,997	3,290		26.00
27.00	Total Inpatient Days (see instructions)	31,235	31,235		27.00
28.00	Ratio of inpatient days to total inpatient days	0.416104	0.105331		28.00
29.00	Program direct GME amount	508,062	128,609		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		18,172		30.00
31.00	Net Program direct GME amount			618,499	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		32,191,452	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)		6,361	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		32,185,091	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		10,976,670	42.00
43.00	Primary payer payments (see instructions)		777	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		10,975,893	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		43,160,984	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.745699	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.254301	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		618,499	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		461,214	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		157,285	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet G		
		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	72,316,000	0	0	0	1.00
2.00	Temporary investments	71,537,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	544,684,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	224,106,000	0	0	0	9.00
10.00	Due from other funds	25,422,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	938,065,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	148,150,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,838,618,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,441,911,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,348,043,000	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)	2,080,636,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,363,740,000	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	379,088,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,742,828,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,761,529,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	325,076,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	370,195,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	57,524,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	421,041,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,173,836,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	1,517,328,000	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	897,259,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,414,587,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,588,423,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,173,106,000	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)	4,173,106,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,761,529,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0127

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

Worksheet G-1

Date/Time Prepared:
5/24/2017 8:22 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		3,678,454,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,053,029			2.00
3.00	Total (sum of line 1 and line 2)		3,683,507,029		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	ADJ TO AHC FUND BALANCE	489,598,971		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		489,598,971		0	10.00
11.00	Subtotal (line 3 plus line 10)		4,173,106,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,173,106,000		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	ADJ TO AHC FUND BALANCE		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0127

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2017 8:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	40,968,567		40,968,567	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,158,645		3,158,645	3.00
4.00	SUBPROVIDER	0		0	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)	44,127,212		44,127,212	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	13,042,974		13,042,974	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)	13,042,974		13,042,974	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	57,170,186		57,170,186	17.00
18.00	Ancillary services	162,280,156	188,794,347	351,074,503	18.00
19.00	Outpatient services	8,220,372	35,527,668	43,748,040	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	227,670,714	224,322,015	451,992,729	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		169,093,572		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		169,093,572		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0127

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

Worksheet G-3

Date/Time Prepared:
5/24/2017 8:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	451,992,729	1.00
2.00	Less contractual allowances and discounts on patients' accounts	285,014,069	2.00
3.00	Net patient revenues (line 1 minus line 2)	166,978,660	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	169,093,572	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,114,912	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,607,771	6.00
7.00	Income from investments	18,821	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	209,023	13.00
14.00	Revenue from meals sold to employees and guests	347,442	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	1,469,792	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	201,839	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	1,202,491	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	1,110,762	24.00
25.00	Total other income (sum of lines 6-24)	7,167,941	25.00
26.00	Total (line 5 plus line 25)	5,053,029	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,053,029	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0127	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/24/2017 8:22 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,670,277	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		68,377	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)		78.77	3.00
4.00	Number of interns & residents (see instructions)		12.57	4.00
5.00	Indirect medical education percentage (see instructions)		4.61	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)		77,000	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		4.22	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.46	8.00
9.00	Sum of lines 7 and 8		26.68	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.55	10.00
11.00	Disproportionate share adjustment (see instructions)		92,700	11.00
12.00	Total prospective capital payments (see instructions)		1,908,354	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