

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: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/31/2017 2:22 pm
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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: 5/31/2017	Time: 2:22 pm
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 SOUTH SHORE HOSPITAL CORPORATION (14-0181) 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	-618,743	-112,321	-12,196	0	1.00
2.00 Subprovider - IPF	0	68,512	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-550,231	-112,321	-12,196	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 2:20 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60617-1175 County: COOK					
1.00 Street: 8012 SOUTH CRANDON AVENUE		2.00 City: CHI CAGO									
		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	
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	SOUTH SHORE HOSPITAL CORPORATION		140181	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SOUTH SHORE HOSPITAL PSYCH UNIT		14S181	16974	4	01/01/2013	N	P	N	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016			20.00
21.00	Type of Control (see instructions)						2				21.00
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						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.	914	852	0	0	7,319	0			24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 2:20 pm			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	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	Y	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
					1.00	2.00	3.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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.	0				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		1,263,852	
					1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 2:20 pm	
		1.00		2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	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	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.25	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 2:20 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2016	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. I, 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: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 2:20 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2017			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/03/2017	Y	05/03/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 2:20 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE REIMBURSEMENT&CONSULTING, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0181

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

Worksheet S-2
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT	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: 14-0181

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	114	41,724	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)		114	41,724	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	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						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		122	44,652	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	15	5,490		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		137			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0181

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,360	1,012	17,991			1.00
2.00 HMO and other (see instructions)	243	7,967				2.00
3.00 HMO IPF Subprovider	0	835				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,360	1,012	17,991			7.00
8.00 INTENSIVE CARE UNIT	835	106	1,454			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						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	9,195	1,118	19,445	0.00	410.38	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,881	112	4,237	0.00	23.22	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	433.60	27.00
28.00 Observation Bed Days		91	1,003			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0181

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,183	200	2,981	1.00
2.00 HMO and other (see instructions)			36	562		2.00
3.00 HMO IPF Subprovider				79		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,183	200	2,981	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	147	9	364	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	21,549,118	0	21,549,118	901,872.00	23.89
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,579,625	49,352	1,628,977	73,345.00	22.21
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		3,260,492	0	3,260,492	32,114.00	101.53
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		603,031	0	603,031	4,020.00	150.01
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		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)		3,566,641	0	3,566,641		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		291,663	0	291,663		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	236,260	0	236,260	8,346.00	28.31
27.00	Administrative & General	5.00	3,664,976	-49,352	3,615,624	134,424.00	26.90

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	813,249	0	813,249	6,866.00	118.45	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	772,814	0	772,814	43,519.00	17.76	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	557,988	0	557,988	47,965.00	11.63	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	732,475	0	732,475	50,783.00	14.42	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	23,199	0	23,199	1,952.00	11.88	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	959,411	0	959,411	25,678.00	37.36	38.00
39.00	Central Services and Supply	121,446	0	121,446	9,443.00	12.86	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	331,631	0	331,631	20,271.00	16.36	41.00
42.00	Social Service	87,915	0	87,915	3,930.00	22.37	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

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

Worksheet S-3
Part III
Date/Time Prepared:
5/31/2017 2:20 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	22,362,367	0	22,362,367	908,738.00	24.61	1.00
2.00	Excluded area salaries (see instructions)	1,579,625	49,352	1,628,977	73,345.00	22.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)	20,782,742	-49,352	20,733,390	835,393.00	24.82	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,863,523	0	3,863,523	36,134.00	106.92	4.00
5.00	Subtotal wage-related costs (see inst.)	3,566,641	0	3,566,641	0.00	17.20	5.00
6.00	Total (sum of lines 3 thru 5)	28,212,906	-49,352	28,163,554	871,527.00	32.32	6.00
7.00	Total overhead cost (see instructions)	8,301,364	-49,352	8,252,012	353,177.00	23.37	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2017 2:20 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		213,698	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		1,724,527	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		28,170	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		26,641	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)		156,960	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		40,133	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		1,572,536	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		53,257	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		42,381	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,858,303	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/31/2017 2:20 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		3,260,492	3,858,303
2.00	Hospital		3,260,492	3,566,640
3.00	Subprovider - IPF		0	228,846
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	62,817

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/31/2017 2:20 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.390125	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		17,196,028	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		57,073,494	6.00
7.00	Medicaid cost (line 1 times line 6)		22,265,797	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)		5,069,769	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)		5,069,769	19.00
			Uninsured patients	Insured patients
			1.00	2.00
20.00	Charity care charges for the entire facility (see instructions)		2,571,572	461,311
21.00	Cost of patients approved for charity care (line 1 times line 20)		1,003,235	179,969
22.00	Partial payment by patients approved for charity care		0	0
23.00	Cost of charity care (line 21 minus line 22)		1,003,235	179,969
			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)		1,276,409	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		594,724	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		681,685	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		265,942	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,449,146	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,518,915	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0181

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

Worksheet A
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		1,284,221	1,284,221	-568,629	715,592	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	568,629	568,629	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	236,260	4,219,500	4,455,760	-1,835,536	2,620,224	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	3,664,976	5,943,625	9,608,601	1,749,845	11,358,446	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	772,814	850,666	1,623,480	0	1,623,480	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	22,454	22,454	8.00
9.00 00900 HOUSEKEEPING	557,988	221,774	779,762	-22,454	757,308	9.00
10.00 01000 DIETARY	732,475	453,833	1,186,308	0	1,186,308	10.00
11.00 01100 CAFETERIA	23,199	167,740	190,939	0	190,939	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	959,411	199,050	1,158,461	0	1,158,461	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	121,446	94,892	216,338	-62,429	153,909	14.00
15.00 01500 PHARMACY	0	3,479,244	3,479,244	-608,049	2,871,195	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	331,631	411,532	743,163	0	743,163	16.00
17.00 01700 SOCIAL SERVICE	87,915	19,334	107,249	0	107,249	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6,088,312	1,471,983	7,560,295	-211,360	7,348,935	30.00
31.00 03100 INTENSIVE CARE UNIT	1,294,274	367,983	1,662,257	-61,995	1,600,262	31.00
40.00 04000 SUBPROVIDER - I/PF	1,278,138	1,098,710	2,376,848	-15,646	2,361,202	40.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	662,270	730,909	1,393,179	-485,575	907,604	50.00
51.00 05100 RECOVERY ROOM	261,189	25,662	286,851	-1,609	285,242	51.00
53.00 05300 ANESTHESIOLOGY	41,128	613,640	654,768	-25,314	629,454	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	364,901	623,065	987,966	-15,000	972,966	54.00
54.01 03630 ULTRA SOUND	128,481	24,167	152,648	-3,539	149,109	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	130,928	172,388	303,316	-38,839	264,477	57.00
58.00 05800 MRI	0	81,239	81,239	-774	80,465	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	817,910	1,050,300	1,868,210	-470,985	1,397,225	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	44,649	287,253	331,902	-34,018	297,884	63.00
65.00 06500 RESPIRATORY THERAPY	530,551	265,475	796,026	-43,023	753,003	65.00
66.00 06600 PHYSICAL THERAPY	170,469	75,443	245,912	-8,453	237,459	66.00
68.00 06800 SPEECH PATHOLOGY	0	40,179	40,179	0	40,179	68.00
69.00 06900 ELECTROCARDIOLOGY	129,143	275,050	404,193	-12,215	391,978	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,759,094	1,759,094	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	90,836	90,836	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	460,075	460,075	73.00
74.00 07400 RENAL DIALYSIS	0	434,702	434,702	-3,722	430,980	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WOUND CARE	0	39,930	39,930	-5,330	34,600	90.01
91.00 09100 EMERGENCY	1,817,173	1,525,142	3,342,315	-202,130	3,140,185	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		0	0	0	0	113.00
118.00	21,247,631	26,548,631	47,796,262	-85,691	47,710,571	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 PHYSICIANS' PRIVATE OFFICES-CLINICS	301,487	285,277	586,764	0	586,764	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 FUND RAISING	0	0	0	26,709	26,709	194.01
194.02 07952 MARKETING OTHER	0	0	0	58,982	58,982	194.02
200.00	21,549,118	26,833,908	48,383,026	0	48,383,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0181

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

Worksheet A
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	715,592	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	568,629	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,620,224	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-289,327	11,069,119	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-65,211	1,558,269	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,454	8.00
9.00	00900	HOUSEKEEPING	0	757,308	9.00
10.00	01000	DIETARY	0	1,186,308	10.00
11.00	01100	CAFETERIA	-200,501	-9,562	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-4,832	1,153,629	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	153,909	14.00
15.00	01500	PHARMACY	0	2,871,195	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-49,677	693,486	16.00
17.00	01700	SOCIAL SERVICE	-3,577	103,672	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-531,489	6,817,446	30.00
31.00	03100	INTENSIVE CARE UNIT	-159,880	1,440,382	31.00
40.00	04000	SUBPROVIDER - I PF	-203,787	2,157,415	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-23,404	884,200	50.00
51.00	05100	RECOVERY ROOM	0	285,242	51.00
53.00	05300	ANESTHESIOLOGY	-577,304	52,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,627	968,339	54.00
54.01	03630	ULTRA SOUND	0	149,109	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	264,477	57.00
58.00	05800	MRI	0	80,465	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-193,761	1,203,464	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	297,884	63.00
65.00	06500	RESPIRATORY THERAPY	-9,663	743,340	65.00
66.00	06600	PHYSICAL THERAPY	0	237,459	66.00
68.00	06800	SPEECH PATHOLOGY	0	40,179	68.00
69.00	06900	ELECTROCARDIOLOGY	-221,947	170,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,759,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	460,075	73.00
74.00	07400	RENAL DIALYSIS	-483	430,497	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CARE	-34,300	300	90.01
91.00	09100	EMERGENCY	-941,310	2,198,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,515,080	44,195,491	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	-14,586	572,178	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	FUND RAISING	0	26,709	194.01
194.02	07952	MARKETING OTHER	0	58,982	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-3,529,666	44,853,360	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - MEDICAL SUPPLIES SOLD TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,849,930	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	TOTALS		0	1,849,930	
B - FUNDRAISING					
1.00	FUNDRAISING	194.01	24,811	1,898	1.00
	TOTALS		24,811	1,898	
C - MARKETING					
1.00	MARKETING OTHER	194.02	24,541	34,441	1.00
	TOTALS		24,541	34,441	
D - NON BENEFITS TO A & G					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,835,536	1.00
	TOTALS		0	1,835,536	
E - DRUGS CHARGED TO					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	460,075	1.00
	TOTALS		0	460,075	
F - COST OF IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	90,836	1.00
	TOTALS		0	90,836	
G - LAUNDRY COSTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	22,454	1.00
	TOTALS		0	22,454	
H - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	568,629	1.00
	TOTALS		0	568,629	
500.00	Grand Total: Increases		49,352	4,863,799	500.00

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
A - MEDICAL SUPPLIES SOLD TO PATIENTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	62,429	0	1.00	
2.00	PHARMACY	15.00	0	147,974	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	211,360	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	61,995	0	4.00	
5.00	SUBPROVIDER - IPF	40.00	0	15,646	0	5.00	
6.00	OPERATING ROOM	50.00	0	485,575	0	6.00	
7.00	RECOVERY ROOM	51.00	0	1,609	0	7.00	
8.00	ANESTHESIOLOGY	53.00	0	25,314	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,000	0	9.00	
10.00	ULTRA SOUND	54.01	0	3,539	0	10.00	
11.00	CT SCAN	57.00	0	38,839	0	11.00	
12.00	MRI	58.00	0	774	0	12.00	
13.00	LABORATORY	60.00	0	470,985	0	13.00	
14.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	34,018	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	43,023	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	8,453	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	12,215	0	17.00	
18.00	RENAL DIALYSIS	74.00	0	3,722	0	18.00	
19.00	WOUND CARE	90.01	0	5,330	0	19.00	
20.00	EMERGENCY	91.00	0	202,130	0	20.00	
	TOTALS		0	1,849,930			
B - FUNDRAISING							
1.00	ADMINISTRATIVE & GENERAL	5.00	24,811	1,898	0	1.00	
	TOTALS		24,811	1,898			
C - MARKETING							
1.00	ADMINISTRATIVE & GENERAL	5.00	24,541	34,441	0	1.00	
	TOTALS		24,541	34,441			
D - NON BENEFITS TO A & G							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,835,536	0	1.00	
	TOTALS		0	1,835,536			
E - DRUGS CHARGED T							
1.00	PHARMACY	15.00	0	460,075	0	1.00	
	TOTALS		0	460,075			
F - COST OF IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	90,836	0	1.00	
	TOTALS		0	90,836			
G - LAUNDRY COSTS							
1.00	HOUSEKEEPING	9.00	0	22,454	0	1.00	
	TOTALS		0	22,454			
H - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	568,629	9	1.00	
	TOTALS		0	568,629			
500.00	Grand Total: Decreases		49,352	4,863,799		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

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

Worksheet A-7
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,467,066	0	0	0	1.00
2.00	Land Improvements	1,100,274	0	0	0	2.00
3.00	Buildings and Fixtures	17,790,291	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	10,405,445	159,131	0	159,131	5.00
6.00	Movable Equipment	21,512,079	461,155	0	461,155	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,275,155	620,286	0	620,286	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,275,155	620,286	0	620,286	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,467,066	0			1.00
2.00	Land Improvements	1,100,274	0			2.00
3.00	Buildings and Fixtures	17,790,291	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	10,564,576	0			5.00
6.00	Movable Equipment	21,921,738	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	52,843,945	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	52,843,945	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

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

Worksheet A-7
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,284,221	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,284,221	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,284,221				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,284,221				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

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

Worksheet A-7
Part III
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	30,922,207	0	30,922,207	0.585161	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,921,738	0	21,921,738	0.414839	0	2.00
3.00	Total (sum of lines 1-2)	52,843,945	0	52,843,945	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	715,592	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	568,629	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,284,221	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	715,592	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	568,629	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,284,221	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0181

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

Worksheet A-8

Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	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)	A	-33,075		ADMINISTRATIVE & GENERAL	5.00		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	-3,010,514					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0				0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-200,501		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others	A	-65,211		OPERATION OF PLANT	7.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-49,677		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 OFFSET A & G MISC INCOME	B	-71,839		ADMINISTRATIVE & GENERAL	5.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0181

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

Worksheet A-8

Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.01	PHYSICIAN PRO FEE	A	-14,586	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01	0	33.01
34.00	LOBBY EXPENSE	A	-17,581	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	LOBBY/EST EXPENSE	A	-66,682	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00			0		0.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,529,666				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0181

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2017 2:20 pm

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	189,021	57,974	131,047	211,500	874	1.00
2.00	13.00 NURSING ADMINISTRATION	15,000	0	15,000	211,500	100	2.00
3.00	17.00 SOCIAL SERVICE	11,000	0	11,000	211,500	73	3.00
4.00	30.00 ADULTS & PEDIATRICS	531,489	531,489	0	0	0	4.00
5.00	31.00 INTENSIVE CARE UNIT	159,880	159,880	0	0	0	5.00
6.00	40.00 SUBPROVIDER - IPF	203,787	203,787	0	0	0	6.00
7.00	50.00 OPERATING ROOM	111,065	0	111,065	246,400	740	7.00
8.00	53.00 ANESTHESIOLOGY	577,304	577,304	0	0	0	8.00
9.00	54.00 RADIOLOGY-DIAGNOSTIC	36,000	0	36,000	271,900	240	9.00
10.00	60.00 LABORATORY	193,761	193,761	0	0	0	10.00
11.00	65.00 RESPIRATORY THERAPY	30,000	0	30,000	211,500	200	11.00
12.00	69.00 ELECTROCARDIOLOGY	221,947	221,947	0	0	0	12.00
13.00	74.00 RENAL DIALYSIS	1,500	0	1,500	211,500	10	13.00
14.00	90.01 WOUND CARE	34,300	34,300	0	0	0	14.00
15.00	91.00 EMERGENCY	1,122,610	855,191	267,419	211,500	1,783	15.00
200.00		3,438,664	2,835,633	603,031		4,020	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	88,871	4,444	0	0	0	1.00
2.00	13.00 NURSING ADMINISTRATION	10,168	508	0	0	0	2.00
3.00	17.00 SOCIAL SERVICE	7,423	371	0	0	0	3.00
4.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	31.00 INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00 SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	50.00 OPERATING ROOM	87,661	4,383	0	0	0	7.00
8.00	53.00 ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	54.00 RADIOLOGY-DIAGNOSTIC	31,373	1,569	0	0	0	9.00
10.00	60.00 LABORATORY	0	0	0	0	0	10.00
11.00	65.00 RESPIRATORY THERAPY	20,337	1,017	0	0	0	11.00
12.00	69.00 ELECTROCARDIOLOGY	0	0	0	0	0	12.00
13.00	74.00 RENAL DIALYSIS	1,017	51	0	0	0	13.00
14.00	90.01 WOUND CARE	0	0	0	0	0	14.00
15.00	91.00 EMERGENCY	181,300	9,065	0	0	0	15.00
200.00		428,150	21,408	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	88,871	42,176	100,150		1.00
2.00	13.00 NURSING ADMINISTRATION	0	10,168	4,832	4,832		2.00
3.00	17.00 SOCIAL SERVICE	0	7,423	3,577	3,577		3.00
4.00	30.00 ADULTS & PEDIATRICS	0	0	0	531,489		4.00
5.00	31.00 INTENSIVE CARE UNIT	0	0	0	159,880		5.00
6.00	40.00 SUBPROVIDER - IPF	0	0	0	203,787		6.00
7.00	50.00 OPERATING ROOM	0	87,661	23,404	23,404		7.00
8.00	53.00 ANESTHESIOLOGY	0	0	0	577,304		8.00
9.00	54.00 RADIOLOGY-DIAGNOSTIC	0	31,373	4,627	4,627		9.00
10.00	60.00 LABORATORY	0	0	0	193,761		10.00
11.00	65.00 RESPIRATORY THERAPY	0	20,337	9,663	9,663		11.00
12.00	69.00 ELECTROCARDIOLOGY	0	0	0	221,947		12.00
13.00	74.00 RENAL DIALYSIS	0	1,017	483	483		13.00
14.00	90.01 WOUND CARE	0	0	0	34,300		14.00
15.00	91.00 EMERGENCY	0	181,300	86,119	941,310		15.00
200.00		0	428,150	174,881	3,010,514		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 2: 20 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	715,592	715,592			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	568,629		568,629		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,620,224	1,768	932	2,622,924	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,069,119	72,028	280,808	444,968	11,866,923
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	1,558,269	51,383	2,940	95,109	1,707,701
8.00 00800	LAUNDRY & LINEN SERVICE	22,454	5,147	0	0	27,601
9.00 00900	HOUSEKEEPING	757,308	16,498	0	68,670	842,476
10.00 01000	DIETARY	1,186,308	15,735	948	90,144	1,293,135
11.00 01100	CAFETERIA	-9,562	14,588	700	2,855	8,581
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,153,629	6,073	13,366	118,073	1,291,141
14.00 01400	CENTRAL SERVICES & SUPPLY	153,909	9,125	1,949	14,946	179,929
15.00 01500	PHARMACY	2,871,195	8,709	231	0	2,880,135
16.00 01600	MEDICAL RECORDS & LIBRARY	693,486	3,368	1,688	40,813	739,355
17.00 01700	SOCIAL SERVICE	103,672	721	0	10,820	115,213
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,817,446	248,451	39,181	749,269	7,854,347
31.00 03100	INTENSIVE CARE UNIT	1,440,382	22,182	18,064	159,284	1,639,912
40.00 04000	SUBPROVIDER - IPF	2,157,415	50,394	19,941	157,298	2,385,048
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	884,200	46,221	62,994	81,504	1,074,919
51.00 05100	RECOVERY ROOM	285,242	3,263	2,256	32,144	322,905
53.00 05300	ANESTHESIOLOGY	52,150	2,179	21,793	5,062	81,184
54.00 05400	RADIOLOGY-DIAGNOSTIC	968,339	30,665	33,439	44,908	1,077,351
54.01 03630	ULTRA SOUND	149,109	1,684	15,824	15,812	182,429
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	264,477	3,100	0	16,113	283,690
58.00 05800	MRI	80,465	0	0	0	80,465
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,203,464	22,103	5,291	100,659	1,331,517
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	297,884	1,631	1,436	5,495	306,446
65.00 06500	RESPIRATORY THERAPY	743,340	13,104	16,844	65,294	838,582
66.00 06600	PHYSICAL THERAPY	237,459	16,819	1,696	20,979	276,953
68.00 06800	SPEECH PATHOLOGY	40,179	0	3,123	0	43,302
69.00 06900	ELECTROCARDIOLOGY	170,031	7,594	16,481	15,893	209,999
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,759,094	0	0	0	1,759,094
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	90,836	0	0	0	90,836
73.00 07300	DRUGS CHARGED TO PATIENTS	460,075	0	0	0	460,075
74.00 07400	RENAL DIALYSIS	430,497	1,500	0	0	431,997
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOUND CARE	300	1,516	0	0	1,816
91.00 09100	EMERGENCY	2,198,875	37,411	2,710	223,636	2,462,632
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	44,195,491	714,960	564,635	2,579,748	44,147,689
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	632	0	0	632
192.01 19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	572,178	0	3,994	37,103	613,275
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	FUND RAISING	26,709	0	0	3,053	29,762
194.02 07952	MARKETING OTHER	58,982	0	0	3,020	62,002
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	44,853,360	715,592	568,629	2,622,924	44,853,360

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/31/2017 2:20 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	11,866,923			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	614,349	0	2,322,050	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	9,930	0	20,242	57,773	8.00	
9.00	00900	HOUSEKEEPING	303,082	0	64,885	4,331	1,214,774	9.00
10.00	01000	DIETARY	465,208	0	61,884	0	0	10.00
11.00	01100	CAFETERIA	3,087	0	57,372	0	16,990	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	464,491	0	23,884	0	8,495	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,730	0	35,889	341	33,980	14.00
15.00	01500	PHARMACY	1,036,134	0	34,254	0	16,990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	265,984	0	13,246	0	38,227	16.00
17.00	01700	SOCIAL SERVICE	41,448	0	2,836	0	4,247	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,825,603	0	977,150	36,426	445,985	30.00
31.00	03100	INTENSIVE CARE UNIT	589,962	0	87,238	6,175	101,939	31.00
40.00	04000	SUBPROVIDER - IPF	858,026	0	198,196	2,518	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	386,704	0	181,783	1,806	135,919	50.00
51.00	05100	RECOVERY ROOM	116,166	0	12,832	370	16,990	51.00
53.00	05300	ANESTHESIOLOGY	29,206	0	8,569	0	93,444	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	387,579	0	120,602	765	0	54.00
54.01	03630	ULTRA SOUND	65,629	0	6,623	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	102,058	0	12,191	0	8,495	57.00
58.00	05800	MRI	28,947	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	479,016	0	86,928	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	110,245	0	6,416	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	301,682	0	51,536	0	21,237	65.00
66.00	06600	PHYSICAL THERAPY	99,634	0	66,148	1,187	21,237	66.00
68.00	06800	SPEECH PATHOLOGY	15,578	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	75,548	0	29,866	1,310	38,227	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	632,838	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,678	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,513	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	155,412	0	5,899	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	653	0	5,961	0	0	90.01
91.00	09100	EMERGENCY	885,937	0	147,136	2,544	186,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,613,057	0	2,319,566	57,773	1,189,290	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	227	0	2,484	0	16,990	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	220,627	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	10,707	0	0	0	4,247	194.01
194.02	07952	MARKETING OTHER	22,305	0	0	0	4,247	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,866,923	0	2,322,050	57,773	1,214,774	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,820,227					10.00
11.00	01100		86,030				11.00
12.00	01200			0			12.00
13.00	01300		3,594		1,791,605		13.00
14.00	01400		1,321			316,190	14.00
15.00	01500						15.00
16.00	01600		2,837				16.00
17.00	01700		550				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,426,604	34,341	0	1,045,003	0	30.00
31.00	03100	57,648	5,148	0	156,605	0	31.00
40.00	04000	335,975	6,757	0	205,564	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	3,629	0	110,383	0	50.00
51.00	05100	0	931	0	28,300	0	51.00
53.00	05300	0	256	0	0	0	53.00
54.00	05400	0	1,871	0	0	0	54.00
54.01	03630	0	422	0	0	0	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	652	0	0	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	0	6,346	0	0	0	60.00
63.00	06300	0	291	0	0	0	63.00
65.00	06500	0	3,419	0	0	0	65.00
66.00	06600	0	1,085	0	0	0	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	998	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	300,664	71.00
72.00	07200	0	0	0	0	15,526	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	8,075	0	245,750	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		1,820,227	82,523	0	1,791,605	316,190	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	3,277	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	128	0	0	0	194.01
194.02	07952	0	102	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,820,227	86,030	0	1,791,605	316,190	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	3,967,513					15.00
16.00	01600		1,059,649				16.00
17.00	01700			164,294			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	600,513	106,276	15,352,248	0	30.00
31.00	03100	0	65,066	11,506	2,721,199	0	31.00
40.00	04000	0	127,441	22,565	4,142,090	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	64,637	19,759	1,979,539	0	50.00
51.00	05100	0	0	4,188	502,682	0	51.00
53.00	05300	0	0	0	212,659	0	53.00
54.00	05400	0	0	0	1,588,168	0	54.00
54.01	03630	0	0	0	255,103	0	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	407,086	0	57.00
58.00	05800	0	0	0	109,412	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	1,903,807	0	60.00
63.00	06300	0	0	0	423,398	0	63.00
65.00	06500	0	0	0	1,216,456	0	65.00
66.00	06600	0	0	0	466,244	0	66.00
68.00	06800	0	0	0	58,880	0	68.00
69.00	06900	0	0	0	355,948	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	2,692,596	0	71.00
72.00	07200	0	0	0	139,040	0	72.00
73.00	07300	3,957,844	0	0	4,583,432	0	73.00
74.00	07400	0	0	0	593,308	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	8,430	0	90.01
91.00	09100	0	201,992	0	4,140,954	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		3,957,844	1,059,649	164,294	43,852,679	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	20,333	0	192.00
192.01	19201	9,669	0	0	846,848	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	44,844	0	194.01
194.02	07952	0	0	0	88,656	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		3,967,513	1,059,649	164,294	44,853,360	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I/PF	40.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	FUND RAISING	194.01
194.02	07952	MARKETING OTHER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,768	932	2,700	2,700 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	72,028	280,808	352,836	459 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	51,383	2,940	54,323	98 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,147	0	5,147	0 8.00
9.00 00900	HOUSEKEEPING	0	16,498	0	16,498	71 9.00
10.00 01000	DIETARY	0	15,735	948	16,683	93 10.00
11.00 01100	CAFETERIA	0	14,588	700	15,288	3 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	6,073	13,366	19,439	122 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	9,125	1,949	11,074	15 14.00
15.00 01500	PHARMACY	0	8,709	231	8,940	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,368	1,688	5,056	42 16.00
17.00 01700	SOCIAL SERVICE	0	721	0	721	11 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	248,451	39,181	287,632	769 30.00
31.00 03100	INTENSIVE CARE UNIT	0	22,182	18,064	40,246	164 31.00
40.00 04000	SUBPROVIDER - I/PF	0	50,394	19,941	70,335	162 40.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	46,221	62,994	109,215	84 50.00
51.00 05100	RECOVERY ROOM	0	3,263	2,256	5,519	33 51.00
53.00 05300	ANESTHESIOLOGY	0	2,179	21,793	23,972	5 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	30,665	33,439	64,104	46 54.00
54.01 03630	ULTRA SOUND	0	1,684	15,824	17,508	16 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	3,100	0	3,100	17 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	22,103	5,291	27,394	104 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	1,631	1,436	3,067	6 63.00
65.00 06500	RESPIRATORY THERAPY	0	13,104	16,844	29,948	67 65.00
66.00 06600	PHYSICAL THERAPY	0	16,819	1,696	18,515	22 66.00
68.00 06800	SPEECH PATHOLOGY	0	0	3,123	3,123	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	7,594	16,481	24,075	16 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	1,500	0	1,500	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	WOUND CARE	0	1,516	0	1,516	0 90.01
91.00 09100	EMERGENCY	0	37,411	2,710	40,121	231 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	714,960	564,635	1,279,595	2,656 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	632	0	632	0 192.00
192.01 19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	3,994	3,994	38 192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	FUND RAISING	0	0	0	0	3 194.01
194.02 07952	MARKETING OTHER	0	0	0	0	3 194.02
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	715,592	568,629	1,284,221	2,700 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 2:20 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	353,295			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	18,289	0	72,710	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	296	0	634	6,077	8.00	
9.00	00900	HOUSEKEEPING	9,023	0	2,032	456	28,080	9.00
10.00	01000	DIETARY	13,849	0	1,938	0	0	10.00
11.00	01100	CAFETERIA	92	0	1,796	0	393	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	13,828	0	748	0	196	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,927	0	1,124	36	785	14.00
15.00	01500	PHARMACY	30,846	0	1,073	0	393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,918	0	415	0	884	16.00
17.00	01700	SOCIAL SERVICE	1,234	0	89	0	98	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,133	0	30,596	3,829	10,309	30.00
31.00	03100	INTENSIVE CARE UNIT	17,563	0	2,732	650	2,356	31.00
40.00	04000	SUBPROVIDER - IPF	25,544	0	6,206	265	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,512	0	5,692	190	3,142	50.00
51.00	05100	RECOVERY ROOM	3,458	0	402	39	393	51.00
53.00	05300	ANESTHESIOLOGY	869	0	268	0	2,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,538	0	3,776	81	0	54.00
54.01	03630	ULTRA SOUND	1,954	0	207	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	3,038	0	382	0	196	57.00
58.00	05800	MRI	862	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	14,261	0	2,722	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,282	0	201	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	8,981	0	1,614	0	491	65.00
66.00	06600	PHYSICAL THERAPY	2,966	0	2,071	125	491	66.00
68.00	06800	SPEECH PATHOLOGY	464	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,249	0	935	138	884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,840	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	973	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,927	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,627	0	185	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	19	0	187	0	0	90.01
91.00	09100	EMERGENCY	26,375	0	4,607	268	4,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	345,737	0	72,632	6,077	27,491	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7	0	78	0	393	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	6,568	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	319	0	0	0	98	194.01
194.02	07952	MARKETING OTHER	664	0	0	0	98	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	353,295	0	72,710	6,077	28,080	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center	Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	00100							1.00
2.00	00200							2.00
4.00	00400							4.00
5.00	00500							5.00
6.00	00600							6.00
7.00	00700							7.00
8.00	00800							8.00
9.00	00900							9.00
10.00	01000	32,563						10.00
11.00	01100	0	15,814					11.00
12.00	01200	0	0	0				12.00
13.00	01300	0	661	0	34,994			13.00
14.00	01400	0	243	0	0	15,204		14.00
15.00	01500	0	0	0	0	0		15.00
16.00	01600	0	522	0	0	0		16.00
17.00	01700	0	101	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	25,522	6,312	0	20,411	0		30.00
31.00	03100	1,031	946	0	3,059	0		31.00
40.00	04000	6,010	1,242	0	4,015	0		40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	667	0	2,156	0		50.00
51.00	05100	0	171	0	553	0		51.00
53.00	05300	0	47	0	0	0		53.00
54.00	05400	0	344	0	0	0		54.00
54.01	03630	0	78	0	0	0		54.01
55.00	05500	0	0	0	0	0		55.00
56.00	05600	0	0	0	0	0		56.00
57.00	05700	0	120	0	0	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	0	1,167	0	0	0		60.00
63.00	06300	0	53	0	0	0		63.00
65.00	06500	0	628	0	0	0		65.00
66.00	06600	0	200	0	0	0		66.00
68.00	06800	0	0	0	0	0		68.00
69.00	06900	0	183	0	0	0		69.00
70.00	07000	0	0	0	0	0		70.00
71.00	07100	0	0	0	0	14,457		71.00
72.00	07200	0	0	0	0	747		72.00
73.00	07300	0	0	0	0	0		73.00
74.00	07400	0	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	0	0	0	0		90.00
90.01	09001	0	0	0	0	0		90.01
91.00	09100	0	1,484	0	4,800	0		91.00
92.00	09200	0	0	0	0	0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300							113.00
118.00								118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0		190.00
191.00	19100	0	0	0	0	0		191.00
192.00	19200	0	0	0	0	0		192.00
192.01	19201	0	602	0	0	0		192.01
193.00	19300	0	0	0	0	0		193.00
194.00	07950	0	0	0	0	0		194.00
194.01	07951	0	24	0	0	0		194.01
194.02	07952	0	19	0	0	0		194.02
200.00								200.00
201.00		0	1,758	0	0	0		201.00
202.00		32,563	17,572	0	34,994	15,204		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	15.00	16.00	17.00	24.00	25.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY	41,252			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,837		16.00
17.00 01700	SOCIAL SERVICE	0	0	2,254	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	8,409	1,458	479,380
31.00 03100	INTENSIVE CARE UNIT	0	911	158	69,816
40.00 04000	SUBPROVIDER - IPF	0	1,784	310	115,873
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	905	271	133,834
51.00 05100	RECOVERY ROOM	0	0	57	10,625
53.00 05300	ANESTHESIOLOGY	0	0	0	27,321
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,889
54.01 03630	ULTRA SOUND	0	0	0	19,763
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0
57.00 05700	CT SCAN	0	0	0	6,853
58.00 05800	MRI	0	0	0	862
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00 06000	LABORATORY	0	0	0	45,648
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	6,609
65.00 06500	RESPIRATORY THERAPY	0	0	0	41,729
66.00 06600	PHYSICAL THERAPY	0	0	0	24,390
68.00 06800	SPEECH PATHOLOGY	0	0	0	3,587
69.00 06900	ELECTROCARDIOLOGY	0	0	0	28,480
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	33,297
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,720
73.00 07300	DRUGS CHARGED TO PATIENTS	41,151	0	0	46,078
74.00 07400	RENAL DIALYSIS	0	0	0	6,312
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	0
90.01 09001	WOUND CARE	0	0	0	1,722
91.00 09100	EMERGENCY	0	2,828	0	85,034
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,151	14,837	2,254	1,268,822
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,110
192.01 19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	101	0	0	11,303
193.00 19300	NONPAID WORKERS	0	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.01 07951	FUND RAISING	0	0	0	444
194.02 07952	MARKETING OTHER	0	0	0	784
200.00	Cross Foot Adjustments				0
201.00	Negative Cost Centers	0	0	0	1,758
202.00	TOTAL (sum lines 118-201)	41,252	14,837	2,254	1,284,221

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	479,380	30.00
31.00	03100 INTENSIVE CARE UNIT	69,816	31.00
40.00	04000 SUBPROVIDER - I PF	115,873	40.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	133,834	50.00
51.00	05100 RECOVERY ROOM	10,625	51.00
53.00	05300 ANESTHESIOLOGY	27,321	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	79,889	54.00
54.01	03630 ULTRA SOUND	19,763	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	6,853	57.00
58.00	05800 MRI	862	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	45,648	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6,609	63.00
65.00	06500 RESPIRATORY THERAPY	41,729	65.00
66.00	06600 PHYSICAL THERAPY	24,390	66.00
68.00	06800 SPEECH PATHOLOGY	3,587	68.00
69.00	06900 ELECTROCARDIOLOGY	28,480	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	33,297	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,720	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	46,078	73.00
74.00	07400 RENAL DIALYSIS	6,312	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
90.01	09001 WOUND CARE	1,722	90.01
91.00	09100 EMERGENCY	85,034	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,268,822	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,110	192.00
192.01	19201 PHYSICIANS' PRIVATE OFFICES-CLINICS	11,303	192.01
193.00	19300 NONPAID WORKERS	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951 FUND RAISING	444	194.01
194.02	07952 MARKETING OTHER	784	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	1,758	201.00
202.00	TOTAL (sum lines 118-201)	1,284,221	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1
Date/Time Prepared:
5/31/2017 2: 20 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	135,979					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		596,384				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	336	978	21,312,858			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,687	294,517	3,615,624	-11,866,923	32,986,437	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	9,764	3,084	772,814	0	1,707,701	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	978	0	0	0	27,601	8.00
9.00 00900	HOUSEKEEPING	3,135	0	557,988	0	842,476	9.00
10.00 01000	DIETARY	2,990	994	732,475	0	1,293,135	10.00
11.00 01100	CAFETERIA	2,772	734	23,199	0	8,581	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,154	14,018	959,411	0	1,291,141	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,734	2,044	121,446	0	179,929	14.00
15.00 01500	PHARMACY	1,655	242	0	0	2,880,135	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	640	1,770	331,631	0	739,355	16.00
17.00 01700	SOCIAL SERVICE	137	0	87,915	0	115,213	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	47,212	41,093	6,088,312	0	7,854,347	30.00
31.00 03100	INTENSIVE CARE UNIT	4,215	18,946	1,294,274	0	1,639,912	31.00
40.00 04000	SUBPROVIDER - IPF	9,576	20,914	1,278,138	0	2,385,048	40.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	8,783	66,069	662,270	0	1,074,919	50.00
51.00 05100	RECOVERY ROOM	620	2,366	261,189	0	322,905	51.00
53.00 05300	ANESTHESIOLOGY	414	22,857	41,128	0	81,184	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,827	35,071	364,901	0	1,077,351	54.00
54.01 03630	ULTRA SOUND	320	16,596	128,481	0	182,429	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700	CT SCAN	589	0	130,928	0	283,690	57.00
58.00 05800	MRI	0	0	0	0	80,465	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	4,200	5,549	817,910	0	1,331,517	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	310	1,506	44,649	0	306,446	63.00
65.00 06500	RESPIRATORY THERAPY	2,490	17,666	530,551	0	838,582	65.00
66.00 06600	PHYSICAL THERAPY	3,196	1,779	170,469	0	276,953	66.00
68.00 06800	SPEECH PATHOLOGY	0	3,275	0	0	43,302	68.00
69.00 06900	ELECTROCARDIOLOGY	1,443	17,285	129,143	0	209,999	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,759,094	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	90,836	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	460,075	73.00
74.00 07400	RENAL DIALYSIS	285	0	0	0	431,997	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	WOUND CARE	288	0	0	0	1,816	90.01
91.00 09100	EMERGENCY	7,109	2,842	1,817,173	0	2,462,632	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	135,859	592,195	20,962,019	-11,866,923	32,280,766	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	120	0	0	0	632	192.00
192.01 19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	4,189	301,487	0	613,275	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	FUND RAISING	0	0	24,811	0	29,762	194.01
194.02 07952	MARKETING OTHER	0	0	24,541	0	62,002	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	715,592	568,629	2,622,924		11,866,923	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.262518	0.953461	0.123068		0.359752	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			2,700		353,295	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000127		0.010710	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		112,192				7.00
8.00	00800		978	466,474			8.00
9.00	00900	0	3,135	34,967	7,150		9.00
10.00	01000	0	2,990	0	0	68,865	10.00
11.00	01100	0	2,772	0	100	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	1,154	0	50	0	13.00
14.00	01400	0	1,734	2,754	200	0	14.00
15.00	01500	0	1,655	0	100	0	15.00
16.00	01600	0	640	0	225	0	16.00
17.00	01700	0	137	0	25	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	47,212	294,107	2,625	53,973	30.00
31.00	03100	0	4,215	49,860	600	2,181	31.00
40.00	04000	0	9,576	20,333	0	12,711	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	8,783	14,586	800	0	50.00
51.00	05100	0	620	2,986	100	0	51.00
53.00	05300	0	414	0	550	0	53.00
54.00	05400	0	5,827	6,179	0	0	54.00
54.01	03630	0	320	0	0	0	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	589	0	50	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	0	4,200	0	0	0	60.00
63.00	06300	0	310	0	0	0	63.00
65.00	06500	0	2,490	0	125	0	65.00
66.00	06600	0	3,196	9,582	125	0	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1,443	10,580	225	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	285	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	288	0	0	0	90.01
91.00	09100	0	7,109	20,540	1,100	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	112,072	466,474	7,000	68,865	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	120	0	100	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	25	0	194.01
194.02	07952	0	0	0	25	0	194.02
200.00							200.00
201.00							201.00
202.00		0	2,322,050	57,773	1,214,774	1,820,227	202.00
203.00		0.000000	20.697109	0.123850	169.898462	26.431816	203.00
204.00		0	72,710	6,077	28,080	32,563	204.00
205.00		0.000000	0.648085	0.013028	3.927273	0.472853	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	29,565					11.00
12.00	01200	0	0				12.00
13.00	01300	1,235	0	420,865			13.00
14.00	01400	454	0	0	1,849,930		14.00
15.00	01500	0	0	0	0	461,199	15.00
16.00	01600	975	0	0	0	0	16.00
17.00	01700	189	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,802	0	245,481	0	0	30.00
31.00	03100	1,769	0	36,788	0	0	31.00
40.00	04000	2,322	0	48,289	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,247	0	25,930	0	0	50.00
51.00	05100	320	0	6,648	0	0	51.00
53.00	05300	88	0	0	0	0	53.00
54.00	05400	643	0	0	0	0	54.00
54.01	03630	145	0	0	0	0	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	224	0	0	0	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	2,181	0	0	0	0	60.00
63.00	06300	100	0	0	0	0	63.00
65.00	06500	1,175	0	0	0	0	65.00
66.00	06600	373	0	0	0	0	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	343	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	1,759,094	0	71.00
72.00	07200	0	0	0	90,836	0	72.00
73.00	07300	0	0	0	0	460,075	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	2,775	0	57,729	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00	11800	28,360	0	420,865	1,849,930	460,075	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	1,126	0	0	0	1,124	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	44	0	0	0	0	194.01
194.02	07952	35	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		86,030	0	1,791,605	316,190	3,967,513	202.00
203.00		2.909860	0.000000	4.256959	0.170920	8.602605	203.00
204.00		17,572	0	34,994	15,204	41,252	204.00
205.00		0.534889	0.000000	0.083148	0.008219	0.089445	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,150	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	74,324	30.00
31.00	03100	INTENSIVE CARE UNIT	8,053	31.00
40.00	04000	SUBPROVIDER - IPF	15,773	40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,000	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
54.01	03630	ULTRA SOUND	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
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 PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE	0	90.01
91.00	09100	EMERGENCY	25,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,150	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	FUND RAISING	0	194.01
194.02	07952	MARKETING OTHER	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,059,649	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.079672	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,837	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.113130	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	15,352,248		15,352,248	0	15,352,248	30.00
31.00	03100 INTENSIVE CARE UNIT	2,721,199		2,721,199	0	2,721,199	31.00
40.00	04000 SUBPROVIDER - I/PF	4,142,090		4,142,090	0	4,142,090	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,979,539		1,979,539	23,404	2,002,943	50.00
51.00	05100 RECOVERY ROOM	502,682		502,682	0	502,682	51.00
53.00	05300 ANESTHESIOLOGY	212,659		212,659	0	212,659	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,588,168		1,588,168	4,627	1,592,795	54.00
54.01	03630 ULTRA SOUND	255,103		255,103	0	255,103	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600 RADIOISOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	407,086		407,086	0	407,086	57.00
58.00	05800 MRI	109,412		109,412	0	109,412	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	1,903,807		1,903,807	0	1,903,807	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	423,398		423,398	0	423,398	63.00
65.00	06500 RESPIRATORY THERAPY	1,216,456	0	1,216,456	9,663	1,226,119	65.00
66.00	06600 PHYSICAL THERAPY	466,244	0	466,244	0	466,244	66.00
68.00	06800 SPEECH PATHOLOGY	58,880	0	58,880	0	58,880	68.00
69.00	06900 ELECTROCARDIOLOGY	355,948		355,948	0	355,948	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,692,596		2,692,596	0	2,692,596	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	139,040		139,040	0	139,040	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,583,432		4,583,432	0	4,583,432	73.00
74.00	07400 RENAL DIALYSIS	593,308		593,308	483	593,791	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	09001 WOUND CARE	8,430		8,430	0	8,430	90.01
91.00	09100 EMERGENCY	4,140,954		4,140,954	86,119	4,227,073	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	810,695		810,695		810,695	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	44,663,374	0	44,663,374	124,296	44,787,670	200.00
201.00	Less Observation Beds	810,695		810,695		810,695	201.00
202.00	Total (see instructions)	43,852,679	0	43,852,679	124,296	43,976,975	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,102,058		20,102,058		30.00
31.00	03100	INTENSIVE CARE UNIT	3,353,899		3,353,899		31.00
40.00	04000	SUBPROVIDER - IPF	4,899,510		4,899,510		40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,374,369	1,241,484	3,615,853	0.547461	50.00
51.00	05100	RECOVERY ROOM	676,611	472,654	1,149,265	0.437394	51.00
53.00	05300	ANESTHESIOLOGY	1,122,863	608,703	1,731,566	0.122813	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,461,692	1,996,207	4,457,899	0.356259	54.00
54.01	03630	ULTRASOUND	352,420	526,527	878,947	0.290237	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	2,659,118	3,967,235	6,626,353	0.061434	57.00
58.00	05800	MRI	216,544	366,810	583,354	0.187557	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	12,821,573	8,388,486	21,210,059	0.089760	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	651,270	96,442	747,712	0.566258	63.00
65.00	06500	RESPIRATORY THERAPY	9,949,978	911,662	10,861,640	0.111996	65.00
66.00	06600	PHYSICAL THERAPY	2,429,602	332,420	2,762,022	0.168805	66.00
68.00	06800	SPEECH PATHOLOGY	108,927	16,965	125,892	0.467702	68.00
69.00	06900	ELECTROCARDIOLOGY	2,194,260	865,182	3,059,442	0.116344	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,511,103	654,167	5,165,270	0.521289	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	129,017	26,735	155,752	0.892701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,322,533	1,369,707	9,692,240	0.472897	73.00
74.00	07400	RENAL DIALYSIS	1,191,723	106,644	1,298,367	0.456965	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	3,748	69,135	72,883	0.115665	90.01
91.00	09100	EMERGENCY	2,011,641	6,552,580	8,564,221	0.483518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	46,665	1,245,882	1,292,547	0.627207	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	82,591,124	29,815,627	112,406,751		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	82,591,124	29,815,627	112,406,751		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
40.00	04000 SUBPROVIDER - IPF		40.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.553934	50.00
51.00	05100 RECOVERY ROOM	0.437394	51.00
53.00	05300 ANESTHESIOLOGY	0.122813	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357297	54.00
54.01	03630 ULTRA SOUND	0.290237	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600 RADIOISOTOPE	0.000000	56.00
57.00	05700 CT SCAN	0.061434	57.00
58.00	05800 MRI	0.187557	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000 LABORATORY	0.089760	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.566258	63.00
65.00	06500 RESPIRATORY THERAPY	0.112885	65.00
66.00	06600 PHYSICAL THERAPY	0.168805	66.00
68.00	06800 SPEECH PATHOLOGY	0.467702	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116344	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.521289	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.892701	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.472897	73.00
74.00	07400 RENAL DIALYSIS	0.457337	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000	90.00
90.01	09001 WOUND CARE	0.115665	90.01
91.00	09100 EMERGENCY	0.493574	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.627207	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,352,248		15,352,248	0	15,352,248	30.00
31.00	03100	INTENSIVE CARE UNIT	2,721,199		2,721,199	0	2,721,199	31.00
40.00	04000	SUBPROVIDER - I/PF	4,142,090		4,142,090	0	4,142,090	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,979,539		1,979,539	23,404	2,002,943	50.00
51.00	05100	RECOVERY ROOM	502,682		502,682	0	502,682	51.00
53.00	05300	ANESTHESIOLOGY	212,659		212,659	0	212,659	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,588,168		1,588,168	4,627	1,592,795	54.00
54.01	03630	ULTRA SOUND	255,103		255,103	0	255,103	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	407,086		407,086	0	407,086	57.00
58.00	05800	MRI	109,412		109,412	0	109,412	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,903,807		1,903,807	0	1,903,807	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	423,398		423,398	0	423,398	63.00
65.00	06500	RESPIRATORY THERAPY	1,216,456	0	1,216,456	9,663	1,226,119	65.00
66.00	06600	PHYSICAL THERAPY	466,244	0	466,244	0	466,244	66.00
68.00	06800	SPEECH PATHOLOGY	58,880	0	58,880	0	58,880	68.00
69.00	06900	ELECTROCARDIOLOGY	355,948		355,948	0	355,948	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,692,596		2,692,596	0	2,692,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	139,040		139,040	0	139,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,583,432		4,583,432	0	4,583,432	73.00
74.00	07400	RENAL DIALYSIS	593,308		593,308	483	593,791	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CARE	8,430		8,430	0	8,430	90.01
91.00	09100	EMERGENCY	4,140,954		4,140,954	86,119	4,227,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	810,695		810,695		810,695	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,663,374	0	44,663,374	124,296	44,787,670	200.00
201.00		Less Observation Beds	810,695		810,695		810,695	201.00
202.00		Total (see instructions)	43,852,679	0	43,852,679	124,296	43,976,975	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XIX			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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,291,707		24,291,707		30.00
31.00	03100	INTENSIVE CARE UNIT	4,885,802		4,885,802		31.00
40.00	04000	SUBPROVIDER - IPF	44,000		44,000		40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,870,650	1,412,545	6,283,195	0.315053	50.00
51.00	05100	RECOVERY ROOM	1,057,792	671,258	1,729,050	0.290727	51.00
53.00	05300	ANESTHESIOLOGY	1,702,461	776,575	2,479,036	0.085783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	809,288	1,781,484	2,590,772	0.613010	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,714,588	343,214	2,057,802	0.000000	56.00
57.00	05700	CT SCAN	3,537,557	3,156,027	6,693,584	0.060817	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	13,436,626	6,685,067	20,121,693	0.094615	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	715,286	64,292	779,578	0.543112	63.00
65.00	06500	RESPIRATORY THERAPY	11,684,314	606,147	12,290,461	0.098976	65.00
66.00	06600	PHYSICAL THERAPY	1,768,656	278,474	2,047,130	0.227755	66.00
68.00	06800	SPEECH PATHOLOGY	78,334	11,752	90,086	0.653598	68.00
69.00	06900	ELECTROCARDIOLOGY	2,308,963	619,783	2,928,746	0.121536	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,372,362	1,201,230	3,573,592	0.753470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,727,730	684,753	9,412,483	0.486952	73.00
74.00	07400	RENAL DIALYSIS	1,894,732	2,209	1,896,941	0.312771	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	1,933,655	4,818,614	6,752,269	0.613269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,113,946	1,113,946	0.727769	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	87,834,503	24,227,370	112,061,873		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	87,834,503	24,227,370	112,061,873		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 2:20 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.318778		50.00
51.00	05100 RECOVERY ROOM	0.290727		51.00
53.00	05300 ANESTHESIOLOGY	0.085783		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.614796		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.060817		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.094615		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.543112		63.00
65.00	06500 RESPIRATORY THERAPY	0.099762		65.00
66.00	06600 PHYSICAL THERAPY	0.227755		66.00
68.00	06800 SPEECH PATHOLOGY	0.653598		68.00
69.00	06900 ELECTROCARDIOLOGY	0.121536		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.753470		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.486952		73.00
74.00	07400 RENAL DIALYSIS	0.313026		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.626023		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.727769		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-0181

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

Worksheet C Part II Date/Time Prepared: 5/31/2017 2:20 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,979,539	133,834	1,845,705	0	0	50.00
51.00	05100 RECOVERY ROOM	502,682	10,625	492,057	0	0	51.00
53.00	05300 ANESTHESIOLOGY	212,659	27,321	185,338	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,588,168	79,889	1,508,279	0	0	54.00
54.01	03630 ULTRASOUND	255,103	19,763	235,340	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	407,086	6,853	400,233	0	0	57.00
58.00	05800 MRI	109,412	862	108,550	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	1,903,807	45,648	1,858,159	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	423,398	6,609	416,789	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	1,216,456	41,729	1,174,727	0	0	65.00
66.00	06600 PHYSICAL THERAPY	466,244	24,390	441,854	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	58,880	3,587	55,293	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	355,948	28,480	327,468	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,692,596	33,297	2,659,299	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	139,040	1,720	137,320	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,583,432	46,078	4,537,354	0	0	73.00
74.00	07400 RENAL DIALYSIS	593,308	6,312	586,996	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOUND CARE	8,430	1,722	6,708	0	0	90.01
91.00	09100 EMERGENCY	4,140,954	85,034	4,055,920	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	810,695	25,314	785,381	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	22,447,837	629,067	21,818,770	0	0	200.00
201.00	Less Observation Beds	810,695	25,314	785,381	0	0	201.00
202.00	Total (line 200 minus line 201)	21,637,142	603,753	21,033,389	0	0	202.00

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

Provider CCN: 14-0181

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

Worksheet C
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,979,539	3,615,853	0.547461		50.00
51.00	05100 RECOVERY ROOM	502,682	1,149,265	0.437394		51.00
53.00	05300 ANESTHESIOLOGY	212,659	1,731,566	0.122813		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,588,168	4,457,899	0.356259		54.00
54.01	03630 ULTRA SOUND	255,103	878,947	0.290237		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000		55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	407,086	6,626,353	0.061434		57.00
58.00	05800 MRI	109,412	583,354	0.187557		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	1,903,807	21,210,059	0.089760		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	423,398	747,712	0.566258		63.00
65.00	06500 RESPIRATORY THERAPY	1,216,456	10,861,640	0.111996		65.00
66.00	06600 PHYSICAL THERAPY	466,244	2,762,022	0.168805		66.00
68.00	06800 SPEECH PATHOLOGY	58,880	125,892	0.467702		68.00
69.00	06900 ELECTROCARDIOLOGY	355,948	3,059,442	0.116344		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,692,596	5,165,270	0.521289		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	139,040	155,752	0.892701		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,583,432	9,692,240	0.472897		73.00
74.00	07400 RENAL DIALYSIS	593,308	1,298,367	0.456965		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000		90.00
90.01	09001 WOUND CARE	8,430	72,883	0.115665		90.01
91.00	09100 EMERGENCY	4,140,954	8,564,221	0.483518		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	810,695	1,292,547	0.627207		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	22,447,837	84,051,284			200.00
201.00	Less Observation Beds	810,695	0			201.00
202.00	Total (line 200 minus line 201)	21,637,142	84,051,284			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	479,380	0	479,380	18,994	25.24	30.00
31.00	INTENSIVE CARE UNIT	69,816	0	69,816	1,454	48.02	31.00
40.00	SUBPROVIDER - IPF	115,873	0	115,873	4,237	27.35	40.00
200.00	Total (Lines 30-199)	665,069		665,069	24,685		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	8,360	211,006				
31.00	INTENSIVE CARE UNIT	835	40,097				
40.00	SUBPROVIDER - IPF	1,881	51,445				
200.00	Total (Lines 30-199)	11,076	302,548				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

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

Worksheet D
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

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	133,834	3,615,853	0.037013	974,747	36,078	50.00
51.00	05100	RECOVERY ROOM	10,625	1,149,265	0.009245	225,195	2,082	51.00
53.00	05300	ANESTHESIOLOGY	27,321	1,731,566	0.015778	411,678	6,495	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,889	4,457,899	0.017921	1,101,601	19,742	54.00
54.01	03630	ULTRA SOUND	19,763	878,947	0.022485	139,647	3,140	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	6,853	6,626,353	0.001034	1,123,800	1,162	57.00
58.00	05800	MRI	862	583,354	0.001478	140,758	208	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	45,648	21,210,059	0.002152	5,469,269	11,770	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,609	747,712	0.008839	236,764	2,093	63.00
65.00	06500	RESPIRATORY THERAPY	41,729	10,861,640	0.003842	2,521,154	9,686	65.00
66.00	06600	PHYSICAL THERAPY	24,390	2,762,022	0.008830	1,202,624	10,619	66.00
68.00	06800	SPEECH PATHOLOGY	3,587	125,892	0.028493	47,646	1,358	68.00
69.00	06900	ELECTROCARDIOLOGY	28,480	3,059,442	0.009309	915,412	8,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,297	5,165,270	0.006446	3,433,006	22,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,720	155,752	0.011043	53,809	594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,078	9,692,240	0.004754	3,623,334	17,225	73.00
74.00	07400	RENAL DIALYSIS	6,312	1,298,367	0.004861	568,347	2,763	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE	1,722	72,883	0.023627	3,617	85	90.01
91.00	09100	EMERGENCY	85,034	8,564,221	0.009929	763,794	7,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	25,314	1,292,547	0.019585	12,365	242	92.00
200.00		Total (Lines 50-199)	629,067	84,051,284		22,968,567	163,577	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,994	0.00	8,360	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,454	0.00	835	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,237	0.00	1,881	0		40.00
200.00		Total (lines 30-199)	24,685		11,076	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,615,853	0.000000	0.000000	974,747	50.00
51.00	05100	RECOVERY ROOM	0	1,149,265	0.000000	0.000000	225,195	51.00
53.00	05300	ANESTHESIOLOGY	0	1,731,566	0.000000	0.000000	411,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,457,899	0.000000	0.000000	1,101,601	54.00
54.01	03630	ULTRA SOUND	0	878,947	0.000000	0.000000	139,647	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	6,626,353	0.000000	0.000000	1,123,800	57.00
58.00	05800	MRI	0	583,354	0.000000	0.000000	140,758	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	21,210,059	0.000000	0.000000	5,469,269	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	747,712	0.000000	0.000000	236,764	63.00
65.00	06500	RESPIRATORY THERAPY	0	10,861,640	0.000000	0.000000	2,521,154	65.00
66.00	06600	PHYSICAL THERAPY	0	2,762,022	0.000000	0.000000	1,202,624	66.00
68.00	06800	SPEECH PATHOLOGY	0	125,892	0.000000	0.000000	47,646	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,059,442	0.000000	0.000000	915,412	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,165,270	0.000000	0.000000	3,433,006	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	155,752	0.000000	0.000000	53,809	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,692,240	0.000000	0.000000	3,623,334	73.00
74.00	07400	RENAL DIALYSIS	0	1,298,367	0.000000	0.000000	568,347	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CARE	0	72,883	0.000000	0.000000	3,617	90.01
91.00	09100	EMERGENCY	0	8,564,221	0.000000	0.000000	763,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,292,547	0.000000	0.000000	12,365	92.00
200.00		Total (lines 50-199)	0	84,051,284			22,968,567	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	252,931	0		50.00
51.00	05100 RECOVERY ROOM	0	103,262	0		51.00
53.00	05300 ANESTHESIOLOGY	0	143,572	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	439,043	0		54.00
54.01	03630 ULTRA SOUND	0	57,793	0		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	707,448	0		57.00
58.00	05800 MRI	0	135,101	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	777,726	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8,160	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	49,371	0		65.00
66.00	06600 PHYSICAL THERAPY	0	16,487	0		66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	282,469	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	379,217	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,089	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	102,243	0		73.00
74.00	07400 RENAL DIALYSIS	0	106,644	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 WOUND CARE	0	17,203	0		90.01
91.00	09100 EMERGENCY	0	745,722	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	220,332	0		92.00
200.00	Total (Lines 50-199)	0	4,548,813	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.547461	252,931	0	0	138,470	50.00
51.00	05100 RECOVERY ROOM	0.437394	103,262	0	0	45,166	51.00
53.00	05300 ANESTHESIOLOGY	0.122813	143,572	0	0	17,633	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.356259	439,043	0	0	156,413	54.00
54.01	03630 ULTRA SOUND	0.290237	57,793	0	0	16,774	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.061434	707,448	0	0	43,461	57.00
58.00	05800 MRI	0.187557	135,101	0	0	25,339	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.089760	777,726	0	0	69,809	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.566258	8,160	0	0	4,621	63.00
65.00	06500 RESPIRATORY THERAPY	0.111996	49,371	0	0	5,529	65.00
66.00	06600 PHYSICAL THERAPY	0.168805	16,487	0	0	2,783	66.00
68.00	06800 SPEECH PATHOLOGY	0.467702	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116344	282,469	0	0	32,864	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.521289	379,217	0	0	197,682	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.892701	4,089	0	0	3,650	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.472897	102,243	0	0	48,350	73.00
74.00	07400 RENAL DIALYSIS	0.456965	106,644	0	0	48,733	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 WOUND CARE	0.115665	17,203	0	0	1,990	90.01
91.00	09100 EMERGENCY	0.483518	745,722	0	0	360,570	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.627207	220,332	0	0	138,194	92.00
200.00	Subtotal (see instructions)		4,548,813	0	0	1,358,031	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		4,548,813	0	0	1,358,031	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 2:20 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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 PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CARE	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period: From 01/01/2016

Worksheet D

Component CCN: 14-S181

To 12/31/2016

Part II
Date/Time Prepared:
5/31/2017 2:20 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	133,834	3,615,853	0.037013	3,454	128	50.00
51.00	05100 RECOVERY ROOM	10,625	1,149,265	0.009245	827	8	51.00
53.00	05300 ANESTHESIOLOGY	27,321	1,731,566	0.015778	1,143	18	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	79,889	4,457,899	0.017921	19,287	346	54.00
54.01	03630 ULTRA SOUND	19,763	878,947	0.022485	3,678	83	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	6,853	6,626,353	0.001034	19,259	20	57.00
58.00	05800 MRI	862	583,354	0.001478	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	45,648	21,210,059	0.002152	370,926	798	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6,609	747,712	0.008839	1,412	12	63.00
65.00	06500 RESPIRATORY THERAPY	41,729	10,861,640	0.003842	32,621	125	65.00
66.00	06600 PHYSICAL THERAPY	24,390	2,762,022	0.008830	40,744	360	66.00
68.00	06800 SPEECH PATHOLOGY	3,587	125,892	0.028493	1,377	39	68.00
69.00	06900 ELECTROCARDIOLOGY	28,480	3,059,442	0.009309	29,037	270	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	33,297	5,165,270	0.006446	45,474	293	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,720	155,752	0.011043	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	46,078	9,692,240	0.004754	339,701	1,615	73.00
74.00	07400 RENAL DIALYSIS	6,312	1,298,367	0.004861	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 WOUND CARE	1,722	72,883	0.023627	0	0	90.01
91.00	09100 EMERGENCY	85,034	8,564,221	0.009929	85,410	848	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,292,547	0.000000	0	0	92.00
200.00	Total (lines 50-199)	603,753	84,051,284		994,350	4,963	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	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	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	3,615,853	0.000000	0.000000	3,454	50.00
51.00	05100 RECOVERY ROOM	0	1,149,265	0.000000	0.000000	827	51.00
53.00	05300 ANESTHESIOLOGY	0	1,731,566	0.000000	0.000000	1,143	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,457,899	0.000000	0.000000	19,287	54.00
54.01	03630 ULTRA SOUND	0	878,947	0.000000	0.000000	3,678	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	6,626,353	0.000000	0.000000	19,259	57.00
58.00	05800 MRI	0	583,354	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	21,210,059	0.000000	0.000000	370,926	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	747,712	0.000000	0.000000	1,412	63.00
65.00	06500 RESPIRATORY THERAPY	0	10,861,640	0.000000	0.000000	32,621	65.00
66.00	06600 PHYSICAL THERAPY	0	2,762,022	0.000000	0.000000	40,744	66.00
68.00	06800 SPEECH PATHOLOGY	0	125,892	0.000000	0.000000	1,377	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,059,442	0.000000	0.000000	29,037	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,165,270	0.000000	0.000000	45,474	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	155,752	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,692,240	0.000000	0.000000	339,701	73.00
74.00	07400 RENAL DIALYSIS	0	1,298,367	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 WOUND CARE	0	72,883	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	8,564,221	0.000000	0.000000	85,410	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,292,547	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	84,051,284			994,350	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,637	0	54.00
54.01	03630 ULTRA SOUND	0	530	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	4,700	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,548	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	54	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WOUND CARE	0	0	0	90.01
91.00	09100 EMERGENCY	0	21	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	11,490	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 2:20 pm
	Title XVIII	Subprovider - IPF	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	0.547461	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.437394	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.122813	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.356259	1,637	0	0	583	54.00
54.01 03630 ULTRA SOUND	0.290237	530	0	0	154	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00 05700 CT SCAN	0.061434	4,700	0	0	289	57.00
58.00 05800 MRI	0.187557	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.089760	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.566258	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.111996	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.168805	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0.467702	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.116344	4,548	0	0	529	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.521289	54	0	0	28	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.892701	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.472897	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.456965	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 WOUND CARE	0.115665	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.483518	21	0	0	10	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.627207	0	0	0	0	92.00
200.00 Subtotal (see instructions)		11,490	0	0	1,593	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		11,490	0	0	1,593	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 2:20 pm
	Title XVIII	Subprovider - IPF	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
54.01 03630 ULTRASOUND	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORAGE, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
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 PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 WOUND CARE	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	479,380	0	479,380	18,994	25.24	30.00
31.00	INTENSIVE CARE UNIT	69,816	0	69,816	1,454	48.02	31.00
40.00	SUBPROVIDER - IPF	115,873	0	115,873	4,237	27.35	40.00
200.00	Total (Lines 30-199)	665,069		665,069	24,685		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,012	25,543				
31.00	INTENSIVE CARE UNIT	106	5,090				
40.00	SUBPROVIDER - IPF	112	3,063				
200.00	Total (Lines 30-199)	1,230	33,696				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

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

Worksheet D
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

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	
Title XIX Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133,834	6,283,195	0.021300	0	0	50.00
51.00	05100	RECOVERY ROOM	10,625	1,729,050	0.006145	0	0	51.00
53.00	05300	ANESTHESIOLOGY	27,321	2,479,036	0.011021	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,889	2,590,772	0.030836	0	0	54.00
54.01	03630	ULTRA SOUND	19,763	0	0.000000	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	2,057,802	0.000000	0	0	56.00
57.00	05700	CT SCAN	6,853	6,693,584	0.001024	0	0	57.00
58.00	05800	MRI	862	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	45,648	20,121,693	0.002269	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,609	779,578	0.008478	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	41,729	12,290,461	0.003395	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,390	2,047,130	0.011914	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,587	90,086	0.039818	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,480	2,928,746	0.009724	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,297	3,573,592	0.009318	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,720	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,078	9,412,483	0.004895	0	0	73.00
74.00	07400	RENAL DIALYSIS	6,312	1,896,941	0.003327	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE	1,722	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	85,034	6,752,269	0.012593	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	25,314	1,113,946	0.022725	0	0	92.00
200.00		Total (lines 50-199)	629,067	82,840,364		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description			Title XIX			Hospital		PPS
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,994	0.00	1,012	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,454	0.00	106	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,237	0.00	112	0		40.00
200.00		Total (lines 30-199)	24,685		1,230	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0181

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0181

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description			Title XIX			Hospital		PPS
			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,283,195	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	1,729,050	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,479,036	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,590,772	0.000000	0.000000	0	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	2,057,802	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	6,693,584	0.000000	0.000000	0	57.00
58.00	05800	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	20,121,693	0.000000	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	779,578	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	12,290,461	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,047,130	0.000000	0.000000	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	90,086	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,928,746	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,573,592	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,412,483	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,896,941	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CARE	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,752,269	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,113,946	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	82,840,364			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 2:20 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	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	0	0	0		54.00
54.01	03630 ULTRA SOUND	0	0	0		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 WOUND CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		18,994	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		18,994	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)		17,991	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)		8,360	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)		15,352,248	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)		15,352,248	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)		15,352,248	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)		808.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,757,137	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)		6,757,137	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	2,721,199	1,454	1,871.53	835	1,562,728	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					47.00	
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,656,137	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,976,002	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)					251,103	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					163,577	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					414,680	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,561,322	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)					1,003	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					808.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					810,695	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	479,380	15,352,248	0.031225	810,695	25,314	90.00
91.00	Nursing School cost	0	15,352,248	0.000000	810,695	0	91.00
92.00	Allied health cost	0	15,352,248	0.000000	810,695	0	92.00
93.00	All other Medical Education	0	15,352,248	0.000000	810,695	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,237	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,237	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,237	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)		1,881	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,142,090	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,142,090	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,142,090	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)		977.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,838,866	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)		1,838,866	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1		
		Component CCN: 14-S181				Date/Time Prepared: 5/31/2017 2:20 pm		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT							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							47.00
Cost Center Description								
					1.00			
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					286,737		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,125,603		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)					51,445		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,963		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					56,408		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,069,195		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: 14-0181 Component CCN: 14-S181		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	115,873	4,142,090	0.027975	0	0	90.00
91.00	Nursing School cost	0	4,142,090	0.000000	0	0	91.00
92.00	Allied health cost	0	4,142,090	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,142,090	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		18,994	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		18,994	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)		17,991	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)		1,012	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)		15,352,248	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)		15,352,248	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)		15,352,248	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)		808.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		817,969	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)		817,969	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm
Title XIX			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	2,721,199	1,454	1,871.53	106	198,382 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					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,016,351 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)					30,633 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					30,633 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					985,718 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)					1,003 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					808.27 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					810,695 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	479,380	15,352,248	0.031225	810,695	25,314	90.00
91.00	Nursing School cost	0	15,352,248	0.000000	810,695	0	91.00
92.00	Allied health cost	0	15,352,248	0.000000	810,695	0	92.00
93.00	All other Medical Education	0	15,352,248	0.000000	810,695	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/31/2017 2:20 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		9,556,849		30.00
31.00	03100 INTENSIVE CARE UNIT		1,948,521		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.553934	974,747	539,946	50.00
51.00	05100 RECOVERY ROOM	0.437394	225,195	98,499	51.00
53.00	05300 ANESTHESIOLOGY	0.122813	411,678	50,559	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357297	1,101,601	393,599	54.00
54.01	03630 ULTRA SOUND	0.290237	139,647	40,531	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.061434	1,123,800	69,040	57.00
58.00	05800 MRI	0.187557	140,758	26,400	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.089760	5,469,269	490,922	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.566258	236,764	134,070	63.00
65.00	06500 RESPIRATORY THERAPY	0.112885	2,521,154	284,600	65.00
66.00	06600 PHYSICAL THERAPY	0.168805	1,202,624	203,009	66.00
68.00	06800 SPEECH PATHOLOGY	0.467702	47,646	22,284	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116344	915,412	106,503	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.521289	3,433,006	1,789,588	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.892701	53,809	48,035	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.472897	3,623,334	1,713,464	73.00
74.00	07400 RENAL DIALYSIS	0.457337	568,347	259,926	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CARE	0.115665	3,617	418	90.01
91.00	09100 EMERGENCY	0.493574	763,794	376,989	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.627207	12,365	7,755	92.00
200.00	Total (sum of lines 50-94 and 96-98)		22,968,567	6,656,137	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)		22,968,567		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/31/2017 2:20 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,155,005		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.553934	3,454	1,913	50.00
51.00	05100 RECOVERY ROOM	0.437394	827	362	51.00
53.00	05300 ANESTHESIOLOGY	0.122813	1,143	140	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357297	19,287	6,891	54.00
54.01	03630 ULTRA SOUND	0.290237	3,678	1,067	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.061434	19,259	1,183	57.00
58.00	05800 MRI	0.187557	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.089760	370,926	33,294	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.566258	1,412	800	63.00
65.00	06500 RESPIRATORY THERAPY	0.112885	32,621	3,682	65.00
66.00	06600 PHYSICAL THERAPY	0.168805	40,744	6,878	66.00
68.00	06800 SPEECH PATHOLOGY	0.467702	1,377	644	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116344	29,037	3,378	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.521289	45,474	23,705	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.892701	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.472897	339,701	160,644	73.00
74.00	07400 RENAL DIALYSIS	0.457337	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CARE	0.115665	0	0	90.01
91.00	09100 EMERGENCY	0.493574	85,410	42,156	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.627207	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		994,350	286,737	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)		994,350		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			7,140,053 1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,128,151 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)			223,195 2.00
2.01	Outlier reconciliation amount			0 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0 2.02
3.00	Managed Care Simulated Payments			0 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			119.26 4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000 21.00
22.00	IME payment adjustment (see instructions)			0 22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0 22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000 26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000 27.00
28.00	IME add-on adjustment amount (see instructions)			0 28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0 28.01
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0 29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			17.64 30.00
31.00	Percentage of Medicaid patient days (see instructions)			46.72 31.00
32.00	Sum of lines 30 and 31			64.36 32.00
33.00	Allowable disproportionate share percentage (see instructions)			42.31 33.00
34.00	Disproportionate share adjustment (see instructions)			980,344 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000281751	0.000270364	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,804,941	1,616,097	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,351,240	407,345	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,758,585		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)	12,230,328		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)		12,230,328	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		849,913	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,080,241	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,080,241	61.00
62.00	Deductibles billed to program beneficiaries		797,094	62.00
63.00	Coinurance billed to program beneficiaries		113,315	63.00
64.00	Allowable bad debts (see instructions)		683,734	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		444,427	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		258,153	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,614,259	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-17,614	70.93
70.94	HRR adjustment amount (see instructions)		-47,543	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 2:20 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			12,549,102	71.00
71.01	Sequestration adjustment (see instructions)			250,982	71.01
72.00	Interim payments			12,916,863	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)			-618,743	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			73,867	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0181

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,140,053	0	7,079,697		7,079,697	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,128,151	0		2,110,162	2,110,162	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	223,195	0	145,655	75,654	221,309	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4231	0.4231	0.4231	0.4231		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	980,344	0	757,141	223,203	980,344	11.00
11.01	Uncompensated care payments	36.00	1,758,585	0	1,351,240	407,345	1,758,585	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,230,328	0	9,413,964	2,816,364	12,230,328	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,230,328	0	9,413,964	2,816,364	12,230,328	15.00
16.00	Payment for inpatient program capital	50.00	849,913	0	654,622	195,291	849,913	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0181

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	10,068,586	3,011,655	13,080,241	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	744,967	0	574,172	170,795	744,967	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,247	0	526	721	1,247	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1392	0.1392	0.1392	0.1392		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	103,699	0	79,924	23,775	103,699	25.00
26.00	Total prospective capital payments (see instructions)	12.00	849,913	0	654,622	195,291	849,913	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.040000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				120,466	120,466	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0181

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,140,053	7,079,697		7,079,697	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,128,151		2,110,162	2,110,162	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	223,195	145,655	75,654	221,309	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4231	0.4231	0.4231		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	980,344	757,141	223,203	980,344	11.00
11.01	Uncompensated care payments	36.00	1,758,585	1,351,240	407,345	1,758,585	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,230,328	9,413,964	2,816,364	12,230,328	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,230,328	9,413,964	2,816,364	12,230,328	15.00
16.00	Payment for inpatient program capital	50.00	849,913	654,622	195,291	849,913	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,068,586	3,011,655	13,080,241	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0181

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	744,967	574,172	170,795	744,967	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	1,247	526	721	1,247	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1392	0.1392	0.1392		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	103,699	79,924	23,775	103,699	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	849,913	654,622	195,291	849,913	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-17,614	-11,946	-5,668	-17,614	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-47,543	-34,691	-12,852	-47,543	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,358,031	2.00
3.00	PPS payments		1,000,735	3.00
4.00	Outlier payment (see instructions)		1,247	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		1,001,982	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		221,421	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)		780,561	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		780,561	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		780,561	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)		123,671	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		80,386	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,695	36.00
37.00	Subtotal (see instructions)		860,947	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		860,947	40.00
40.01	Sequestration adjustment (see instructions)		17,219	40.01
41.00	Interim payments		956,049	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-112,321	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			1,593 2.00
3.00	PPS payments			2,841 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 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)			0 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 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)			0 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)			2,841 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			676 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)			2,165 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,165 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			2,165 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			2,165 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,165 40.00
40.01	Sequestration adjustment (see instructions)			43 40.01
41.00	Interim payments			2,122 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			0 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: 14-0181

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		11,976,343		764,948	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		96,578	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/29/2016	1,171,686	12/29/2016	165,637	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	08/23/2016	231,166	08/23/2016	71,114	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)		940,520		94,523	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)		12,916,863		956,049	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		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		618,743		112,321	6.02	
7.00	Total Medicare program liability (see instructions)		12,298,120		843,728	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: 14-0181
Component CCN: 14-S181

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2017 2:20 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,628,151		2,122	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)		62,472		0	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	08/23/2016	62,472		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)		-62,472		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)		1,628,151		2,122	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		68,512		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,696,663		2,122	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0181

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

Worksheet E-1
Part II
Date/Time Prepared:
5/31/2017 2:20 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			2,981 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			9,195 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			243 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			19,445 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			112,406,751 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			3,032,883 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)			295,090 8.00
9.00	Sequestration adjustment amount (see instructions)			5,902 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			289,188 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			301,384 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)			-12,196 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,769,896 1.00
2.00	Net IPF PPS Outlier Payments			18,266 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			11.576503 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,788,162 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,788,162 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,788,162 18.00
19.00	Deductibles			105,532 19.00
20.00	Subtotal (line 18 minus line 19)			1,682,630 20.00
21.00	Coinsurance			21,252 21.00
22.00	Subtotal (line 20 minus line 21)			1,661,378 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			107,555 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			69,911 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			46,251 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,731,289 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,731,289 31.00
31.01	Sequestration adjustment (see instructions)			34,626 31.01
32.00	Interim payments			1,628,151 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			68,512 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			18,266 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0181

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

Worksheet G

Date/Time Prepared:
5/31/2017 2:20 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	730,311	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,671,376	0	0	0	4.00
5.00	Other receivable	2,643,973	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	347,655	0	0	0	7.00
8.00	Prepaid expenses	170,183	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,563,498	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,474,845	0	0	0	12.00
13.00	Land improvements	1,100,274	0	0	0	13.00
14.00	Accumulated depreciation	-1,089,455	0	0	0	14.00
15.00	Buildings	17,790,291	0	0	0	15.00
16.00	Accumulated depreciation	-9,943,396	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	10,611,782	0	0	0	19.00
20.00	Accumulated depreciation	-9,634,747	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	21,794,300	0	0	0	23.00
24.00	Accumulated depreciation	-19,950,158	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)	12,153,736	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,085,877	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	3,547,545	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,633,422	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,350,656	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,888,260	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,804,190	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,510,737	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,203,187	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,878,351	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,878,351	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,081,538	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,269,118				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,269,118	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,350,656	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0181

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

Worksheet G-1

Date/Time Prepared:
5/31/2017 2:20 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		17,834,424		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,565,306			2.00
3.00	Total (sum of line 1 and line 2)		15,269,118		0	3.00
4.00		0		0		4.00
5.00		0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		15,269,118		0	11.00
12.00		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)		15,269,118		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			0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00			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: 14-0181

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2017 2:20 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	20,102,058		20,102,058	1.00
2.00	SUBPROVIDER - IPF	4,899,510		4,899,510	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	25,001,568		25,001,568	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,594,820		4,594,820	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				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,594,820		4,594,820	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	29,596,388		29,596,388	17.00
18.00	Ancillary services	53,061,953		53,061,953	18.00
19.00	Outpatient services	0	29,748,410	29,748,410	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (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)	82,658,341	29,748,410	112,406,751	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,383,026		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)		48,383,026		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0181

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

Worksheet G-3

Date/Time Prepared:
5/31/2017 2:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	112,406,751	1.00
2.00	Less contractual allowances and discounts on patients' accounts	70,509,282	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,897,469	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,383,026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,485,557	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,035,595	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	884,658	24.00
25.00	Total other income (sum of lines 6-24)	3,920,253	25.00
26.00	Total (line 5 plus line 25)	-2,565,304	26.00
27.00	RECONCILING ITEM	2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,565,306	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0181	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/31/2017 2:20 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		744,967	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,247	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)		53.13	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		17.64	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		46.72	8.00
9.00	Sum of lines 7 and 8		64.36	9.00
10.00	Allowable disproportionate share percentage (see instructions)		13.92	10.00
11.00	Disproportionate share adjustment (see instructions)		103,699	11.00
12.00	Total prospective capital payments (see instructions)		849,913	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