

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: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/29/2017 11:46 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/29/2017 Time: 11:46 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SOUTH SUBURBAN HOSPITAL (14-0250) 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)

 CORPORATE DIRECTOR OF REIMBURSEMENT
 Title _____
 05/30/2017
 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	125,979	19,349	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	35,059	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	161,038	19,349	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0250		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/29/2017 11:44 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 178TH STREET AND KEDZIE AVE			PO Box:							1.00
2.00	City: HAZELCREST			State: IL		Zip Code: 60429-		County: COOK			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SOUTH SUBURBAN HOSPITAL	140250	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										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		SOUTH SUBURBAN NURSING UNIT	145599	16974		05/01/1988	N	P	O	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
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016		20.00	
21.00	Type of Control (see instructions)						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.			0	2,419	0	45	7,600	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: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/29/2017 11:44 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
	1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		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	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.	1				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	192,021		17,535,000		223,571	
					1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0250		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/29/2017 11:44 am	
		1.00		2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H036		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ADVOCATE HEALTHCARE	Contractor's Name: NATIONAL GOV'T SERV		Contractor's Number: 06101		141.00	
142.00	Street: 3075 HIGHLAND PARKWAY	PO Box:				142.00	
143.00	City: DOWNERS GROVE	State: IL		Zip Code: 60515		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		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						
161.10	CORF			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/29/2017 11:44 am
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	12/31/2016	170.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0250		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/29/2017 11:44 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				Y		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/16/2017	Y	05/16/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/29/2017 11:44 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GARY		WILLIAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTH CARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5650		GARY.WILLIAMS@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/29/2017 11:44 am
		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.	SR REIMBURSEMENT SPECIALIST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0250

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	223	81,618	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)		223	81,618	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,320	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		243	88,938	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	41	15,006		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		284				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: 14-0250

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,024	1,390	34,771			1.00
2.00 HMO and other (see instructions)	8,218	7,600				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	13,024	1,390	34,771			7.00
8.00 INTENSIVE CARE UNIT	2,138	388	5,742			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		412	2,275			13.00
14.00 Total (see instructions)	15,162	2,190	42,788	0.00	1,013.43	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	4,322	0	9,145	0.00	36.31	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	1,164			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	1,049.74	27.00
28.00 Observation Bed Days		383	9,740			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	273	350			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: 14-0250

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	3,265	445	9,835	1.00
2.00 HMO and other (see instructions)				1,733	2,512		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		3,265	445	9,835	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0			0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						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: 14-0250

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2017 11:44 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	71,727,091	0	71,727,091	2,191,097.44	32.74
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		628,286	0	628,286	1,654.72	379.69
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		97,083	0	97,083	1.00	97,083.00
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	2,155,069	33,591	2,188,660	75,731.77	28.90
10.00	Excluded area salaries (see instructions)		0	30,000	30,000	307.19	97.66
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		5,687,278	0	5,687,278	94,204.65	60.37
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		220,508	0	220,508	1,350.73	163.25
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		7,569,309	0	7,569,309	118,400.00	63.93
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)		17,702,548	0	17,702,548		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		563,169	0	563,169		
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		1,707,262	0	1,707,262		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,554,740	-1,313,379	241,361	7,404.00	32.60
27.00	Administrative & General	5.00	6,844,631	-186,453	6,658,178	162,455.00	40.98

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0250

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2017 11:44 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		942,171	0	942,171	5,594.00	168.43	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,051,923	23,795	2,075,718	74,334.00	27.92	30.00
31.00	Laundry & Linen Service	8.00	142,534	1,400	143,934	8,843.00	16.28	31.00
32.00	Housekeeping	9.00	1,445,857	14,191	1,460,048	101,866.00	14.33	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,770,054	-758,511	1,011,543	58,789.00	17.21	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	781,141	781,141	46,414.00	16.83	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,390,971	88,380	5,479,351	126,665.00	43.26	38.00
39.00	Central Services and Supply	14.00	371,899	61,501	433,400	18,438.00	23.51	39.00
40.00	Pharmacy	15.00	2,893,526	36,161	2,929,687	62,488.00	46.88	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	902,653	3,771	906,424	23,026.00	39.37	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0250

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2017 11:44 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	72,572,179	0	72,572,179	2,196,690.44	33.04	1.00
2.00	Excluded area salaries (see instructions)	2,155,069	63,591	2,218,660	76,038.96	29.18	2.00
3.00	Subtotal salaries (line 1 minus line 2)	70,417,110	-63,591	70,353,519	2,120,651.48	33.18	3.00
4.00	Subtotal other wages & related costs (see inst.)	13,477,095	0	13,477,095	213,955.38	62.99	4.00
5.00	Subtotal wage-related costs (see inst.)	19,409,810	0	19,409,810	0.00	27.59	5.00
6.00	Total (sum of lines 3 thru 5)	103,304,015	-63,591	103,240,424	2,334,606.86	44.22	6.00
7.00	Total overhead cost (see instructions)	24,310,959	-1,248,003	23,062,956	696,316.00	33.12	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2017 11:44 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,521,798 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			1,279,138 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			150,850 6.00
7.00	Employee Managed Care Program Administration Fees			875,835 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			4,470,431 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			1,415,037 9.00
10.00	Dental, Hearing and Vision Plan			257,625 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			69,700 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)			449,048 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			2,051,283 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			5,101,364 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			62,837 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))			189,955 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			370,816 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			18,265,717 24.00
Part B - Other than Core Related Cost				
25.00	OTHER EMPLOYEE COSTS			132,807 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/29/2017 11:44 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		5,687,278	18,265,717
2.00	Hospital		5,687,278	17,702,548
3.00	Subprovider - IPF			
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF		0	563,169
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA		0	0
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC		0	0
15.00	Hospital-Based Health Clinic FQHC		0	0
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
17.00	Renal Dialysis		0	0
18.00	Other		0	0

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0250

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

Worksheet S-7

Date/Time Prepared:
5/29/2017 11:44 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	12	0	12	5.00
6.00	RVL	2	0	2	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	148	0	148	12.00
13.00	RUB	496	0	496	13.00
14.00	RUA	731	0	731	14.00
15.00	RVC	432	0	432	15.00
16.00	RVB	556	0	556	16.00
17.00	RVA	1,140	0	1,140	17.00
18.00	RHC	75	0	75	18.00
19.00	RHB	165	0	165	19.00
20.00	RHA	210	0	210	20.00
21.00	RMC	18	0	18	21.00
22.00	RMB	47	0	47	22.00
23.00	RMA	122	0	122	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	18	0	18	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	27	0	27	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	5	0	5	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	13	0	13	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	17	0	17	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	38	0	38	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	0	0	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0250

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

Worksheet S-7

Date/Time Prepared:
5/29/2017 11:44 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	9	0	9	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	11	0	11	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	28	0	28	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	2	0	2	199.00
200.00	TOTAL		4,322	0	4,322	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

SNF SERVICES				
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	2,155,069	24.18	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	8,911,680			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/29/2017 11:44 am
				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)		0.210596	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		23,429,972	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		177,242,818	6.00
7.00	Medicaid cost (line 1 times line 6)		37,326,628	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		13,896,656	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		13,896,656	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Charity care charges for the entire facility (see instructions)	7,102,067	1,590,793	8,692,860
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,495,667	335,015	1,830,682
22.00	Partial payment by patients approved for charity care	137,824	65,892	203,716
23.00	Cost of charity care (line 21 minus line 22)	1,357,843	269,123	1,626,966
				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)		21,189,151	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,106,299	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		20,082,852	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		4,229,368	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,856,334	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		19,752,990	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0250

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

Worksheet A
Date/Time Prepared:
5/29/2017 11:44 am

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		4,849,871	4,849,871	4,095,954	8,945,825	1.00
3.00	00300		0	0	0	0	3.00
4.00	00400						4.00
5.00	00500	1,554,740	13,406,373	14,961,113	-1,313,939	13,647,174	4.00
5.00	00500	6,844,631	44,309,000	51,153,631	-622,627	50,531,004	5.00
7.00	00700	2,051,923	4,817,688	6,869,611	-114,744	6,754,867	7.00
8.00	00800	142,534	722,442	864,976	-1,264	863,712	8.00
9.00	00900	1,445,857	1,007,373	2,453,230	-1,938	2,451,292	9.00
10.00	01000	1,770,054	1,610,492	3,380,546	-1,502,462	1,878,084	10.00
11.00	01100	0	0	0	1,491,866	1,491,866	11.00
13.00	01300	5,390,971	553,083	5,944,054	75,956	6,020,010	13.00
14.00	01400	371,899	395,069	766,968	-52,199	714,769	14.00
15.00	01500	2,893,526	14,234,840	17,128,366	-14,057,477	3,070,889	15.00
16.00	01600	0	17,749	17,749	-2,119	15,630	16.00
17.00	01700	902,653	91,013	993,666	3,738	997,404	17.00
23.00	02301	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,655,783	7,654,794	26,310,577	-2,734,994	23,575,583	30.00
31.00	03100	3,583,501	2,265,380	5,848,881	-524,266	5,324,615	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	492,188	631,041	1,123,229	-77,041	1,046,188	43.00
44.00	04400	2,155,069	400,787	2,555,856	-112,943	2,442,913	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,461,686	14,069,588	18,531,274	-12,230,151	6,301,123	50.00
53.00	05300	135,485	349,248	484,733	896,251	1,380,984	53.00
54.00	05400	4,656,264	2,283,575	6,939,839	-1,649,530	5,290,309	54.00
56.00	05600	302,424	660,213	962,637	-3,408	959,229	56.00
56.01	05601	673,923	141,208	815,131	-65,273	749,858	56.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	1,238,604	4,533,882	5,772,486	-3,867,530	1,904,956	59.00
60.00	06000	0	6,971,675	6,971,675	-1,927	6,969,748	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	1,372,781	1,372,781	-876,205	496,576	62.00
64.00	06400	350,108	220,510	570,618	-151,916	418,702	64.00
65.00	06500	1,493,128	529,671	2,022,799	-163,707	1,859,092	65.00
66.00	06600	92,285	4,329,237	4,421,522	-1,457,306	2,964,216	66.00
67.00	06700	0	348	348	1,429,109	1,429,457	67.00
68.00	06800	284,291	26,359	310,650	-500	310,150	68.00
69.00	06900	893,936	279,145	1,173,081	86,241	1,259,322	69.00
70.00	07000	89,824	42,608	132,432	-12,502	119,930	70.00
71.00	07100	0	0	0	12,323,615	12,323,615	71.00
72.00	07200	0	0	0	8,979,669	8,979,669	72.00
73.00	07300	0	0	0	13,937,170	13,937,170	73.00
74.00	07400	449,626	315,253	764,879	-187,290	577,589	74.00
75.00	07500	1,440,554	344,731	1,785,285	-97,817	1,687,468	75.00
76.00	03560	72,321	8,106	80,427	-2,018	78,409	76.00
76.97	07697	307,469	49,493	356,962	43,622	400,584	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	2,056,211	1,149,691	3,205,902	-805,118	2,400,784	90.00
91.00	09100	4,473,623	4,340,754	8,814,377	-702,886	8,111,491	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	87	87	-87	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	1,536,405	1,536,405	0	1,536,405	113.00
114.00	11400	0	0	0	30,000	30,000	114.00
118.00		71,727,091	140,521,563	212,248,654	7	212,248,661	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0250		Period: From 01/01/2016 To 12/31/2016		Worksheet A Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77,402	77,402	0	77,402	190.00
190.01	19001	NONREIMBURSABLE HHA	0	28,283	28,283	-7	28,276	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	71,727,091	140,627,248	212,354,339	0	212,354,339	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0250

Period:
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1,689,996	10,635,821	1.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3,228,020	16,875,194	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-22,039,514	28,491,490	5.00
7.00	00700 OPERATION OF PLANT	-1,050	6,753,817	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	863,712	8.00
9.00	00900 HOUSEKEEPING	-1,383	2,449,909	9.00
10.00	01000 DIETARY	0	1,878,084	10.00
11.00	01100 CAFETERIA	-511,833	980,033	11.00
13.00	01300 NURSING ADMINISTRATION	-1,852	6,018,158	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	714,769	14.00
15.00	01500 PHARMACY	-176	3,070,713	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	15,630	16.00
17.00	01700 SOCIAL SERVICE	-22,216	975,188	17.00
23.00	02301 PARAMEDICAL ED PRGM	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2,694,900	20,880,683	30.00
31.00	03100 INTENSIVE CARE UNIT	-14	5,324,601	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	-495,000	551,188	43.00
44.00	04400 SKILLED NURSING FACILITY	0	2,442,913	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-437	6,300,686	50.00
53.00	05300 ANESTHESIOLOGY	-1,084,430	296,554	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-11,000	5,279,309	54.00
56.00	05600 RADIOISOTOPE	-13,102	946,127	56.00
56.01	05601 ULTRASOUND	0	749,858	56.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,904,956	59.00
60.00	06000 LABORATORY	-362,670	6,607,078	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	496,576	62.00
64.00	06400 INTRAVENOUS THERAPY	0	418,702	64.00
65.00	06500 RESPIRATORY THERAPY	-481	1,858,611	65.00
66.00	06600 PHYSICAL THERAPY	-210	2,964,006	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,429,457	67.00
68.00	06800 SPEECH PATHOLOGY	0	310,150	68.00
69.00	06900 ELECTROCARDIOLOGY	-4,942	1,254,380	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	119,930	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,323,615	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	8,979,669	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,937,170	73.00
74.00	07400 RENAL DIALYSIS	0	577,589	74.00
75.00	07500 ASC (NON-DISTINCT PART)	-43	1,687,425	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	78,409	76.00
76.97	07697 CARDIAC REHABILITATION	0	400,584	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	-478	2,400,306	90.00
91.00	09100 EMERGENCY	-2,471,793	5,639,698	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04950 SLEEP LAB	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0	0	112.00
113.00	11300 INTEREST EXPENSE	-1,536,405	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	-30,000	0	114.00
118.00	11800 SUBTOTALS (SUM OF LINES 1-117)	-26,365,913	185,882,748	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77,402	190.00
190.01	19001 NONREIMBURSABLE HHA	-28,276	0	190.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Prepared: 5/29/2017 11:44 am
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6.00	7.00	
194.00	07950	FUND RAISING	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-26,394,189	185,960,150	194.00
					200.00

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	781,141	710,725	1.00
	TOTALS		781,141	710,725	
B - PATIENT DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,937,170	1.00
	TOTALS		0	13,937,170	
C - PHYSICIAN COMPENSATION					
1.00	UTILIZATION REVIEW-SNF	114.00	30,000	0	1.00
	TOTALS		30,000	0	
D - CENTRAL PROCESSING					
1.00	CENTRAL SERVICES & SUPPLY	14.00	52,655	0	1.00
	TOTALS		52,655	0	
E - MEDICAL DIRECTORS - PHYSICIANS					
1.00	ADULTS & PEDIATRICS	30.00	71,537	2,083	1.00
2.00	SKILLED NURSING FACILITY	44.00	10,890	0	2.00
3.00	OPERATING ROOM	50.00	185,878	99,200	3.00
4.00	ANESTHESIOLOGY	53.00	0	1,109,430	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,000	5.00
6.00	RESPIRATORY THERAPY	65.00	81,120	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	38,000	0	7.00
8.00	RENAL DIALYSIS	74.00	16,380	0	8.00
9.00		0.00	0	0	9.00
10.00	CLINIC	90.00	10,000	46,360	10.00
11.00	EMERGENCY	91.00	64,000	38,500	11.00
	TOTALS		477,805	1,326,573	
F - SLEEP LAB					
1.00	CLINIC	90.00	0	87	1.00
	TOTALS		0	87	
G - CONTRACTED OR NURSE ASSISTANTS					
1.00	OPERATING ROOM	50.00	0	99,200	1.00
	TOTALS		0	99,200	
H - EQUIP DEPR					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,095,954	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
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
	TOTALS		0	4,095,954	
I - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	1,429,314	1.00
	TOTALS		0	1,429,314	

RECLASSIFICATIONS

Provider CCN: 14-0250

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

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
J - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	21,303,284	1.00
2.00		0.00	0	0	2.00
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
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
TOTALS			0	21,303,284	
K - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,979,669	1.00
TOTALS			0	8,979,669	
L - CARDIOLOGY ADMINISTRATION					
1.00	CARDIAC CATHETERIZATION	59.00	208,988	21,234	1.00
2.00	ELECTROCARDIOLOGY	69.00	150,832	15,325	2.00
3.00	CARDIAC REHABILITATION	76.97	51,879	5,271	3.00
TOTALS			411,699	41,830	
M - MANAGEMENT INCENTIVES					
1.00	ADMINISTRATIVE & GENERAL	5.00	763,697	0	1.00
2.00	OPERATION OF PLANT	7.00	12,676	0	2.00
3.00	DIETARY	10.00	6,303	0	3.00
4.00	NURSING ADMINISTRATION	13.00	77,417	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	6,397	0	5.00
6.00	PHARMACY	15.00	26,442	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	30,924	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6,192	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	7,815	0	9.00
10.00	OPERATING ROOM	50.00	1,843	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	25,939	0	11.00
12.00	RESPIRATORY THERAPY	65.00	6,397	0	12.00
13.00	ASC (NON-DISTINCT PART)	75.00	7,247	0	13.00
14.00	EMERGENCY	91.00	6,782	0	14.00
TOTALS			986,071	0	
N - ASSOCIATE BONUSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	22,009	0	1.00
2.00	OPERATION OF PLANT	7.00	11,119	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	1,400	0	3.00
4.00	HOUSEKEEPING	9.00	14,191	0	4.00
5.00	DIETARY	10.00	16,327	0	5.00
6.00	NURSING ADMINISTRATION	13.00	10,963	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	2,449	0	7.00
8.00	PHARMACY	15.00	9,719	0	8.00
9.00	SOCIAL SERVICE	17.00	3,771	0	9.00
11.00	ADULTS & PEDIATRICS	30.00	100,629	0	11.00

RECLASSIFICATIONS

Provider CCN: 14-0250

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

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
12.00	INTENSIVE CARE UNIT	31.00	13,101	0		12.00
13.00	NURSERY	43.00	1,865	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	14,886	0		14.00
15.00	OPERATING ROOM	50.00	18,583	0		15.00
16.00	ANESTHESIOLOGY	53.00	661	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	24,683	0		17.00
18.00	RADIOISOTOPE	56.00	1,205	0		18.00
19.00	ULTRASOUND	56.01	2,954	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	4,121	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	1,283	0		21.00
22.00	RESPIRATORY THERAPY	65.00	6,803	0		22.00
23.00	PHYSICAL THERAPY	66.00	350	0		23.00
24.00	SPEECH PATHOLOGY	68.00	894	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	5,597	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	700	0		26.00
27.00	RENAL DIALYSIS	74.00	1,361	0		27.00
28.00	ASC (NON-DISTINCT PART)	75.00	6,335	0		28.00
29.00	PULMONARY FUNCTION TESTING	76.00	311	0		29.00
30.00	CARDIAC REHABILITATION	76.97	1,166	0		30.00
31.00	CLINIC	90.00	8,436	0		31.00
32.00	EMERGENCY	91.00	19,436	0		32.00
	TOTALS		327,308	0		
500.00	Grand Total: Increases		3,066,679	51,923,806		500.00

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA COSTS						
1.00	DIETARY	10.00	781,141	710,725	0	1.00
	TOTALS		781,141	710,725		
B - PATIENT DRUGS						
1.00	PHARMACY	15.00	0	13,937,170	0	1.00
	TOTALS		0	13,937,170		
C - PHYSICIAN COMPENSATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	30,000	0	0	1.00
	TOTALS		30,000	0		
D - CENTRAL PROCESSING						
1.00	ADMINISTRATIVE & GENERAL	5.00	52,655	0	0	1.00
	TOTALS		52,655	0		
E - MEDICAL DIRECTORS - PHYSICIANS						
1.00	ADMINISTRATIVE & GENERAL	5.00	477,805	241,593	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,084,430	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00	PULMONARY FUNCTION TESTING	76.00	0	550	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
	TOTALS		477,805	1,326,573		
F - SLEEP LAB						
1.00	SLEEP LAB	93.00	0	87	0	1.00
	TOTALS		0	87		
G - CONTRACTED OR NURSE ASSISTANTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	99,200	0	1.00
	TOTALS		0	99,200		
H - EQUIP DEPR						
1.00		0.00	0	0	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,165	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,915	0	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	27,223	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	170	0	5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	640	0	6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	17,504	0	7.00
8.00	OPERATION OF PLANT	7.00	0	137,183	0	8.00
9.00	HOUSEKEEPING	9.00	0	12,085	0	9.00
10.00	DIETARY	10.00	0	31,967	0	10.00
11.00	NURSING ADMINISTRATIVE	13.00	0	11,762	0	11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,660	0	12.00
13.00	PHARMACY	15.00	0	131,095	0	13.00
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,119	0	14.00
16.00	ADULTS & PEDIATRICS	30.00	0	602,073	0	16.00
17.00	INTENSIVE CARE UNIT	31.00	0	56,339	0	17.00
18.00	NURSERY	43.00	0	39,157	0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0	1,886	0	19.00
20.00	OPERATING ROOM	50.00	0	1,002,850	0	20.00
21.00	ANESTHESIOLOGY	53.00	0	65,189	0	21.00
22.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,109,498	0	22.00
23.00	RADIOISOTOPE	56.00	0	262	0	23.00
24.00	ULTRASOUND	56.01	0	32,731	0	24.00
25.00	CARDIAC CATHETERIZATION	59.00	0	323,507	0	25.00
26.00	LABORATORY	60.00	0	1,817	0	26.00
27.00	INTRAVENOUS THERAPY	64.00	0	9,069	0	27.00
28.00	RESPIRATORY THERAPY	65.00	0	15,616	0	28.00
29.00	PHYSICAL THERAPY	66.00	0	7,288	0	29.00
30.00	OCCUPATIONAL THERAPY	67.00	0	205	0	30.00
31.00	ELECTROCARDIOLOGY	69.00	0	104,457	0	31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,235	0	32.00
33.00	RENAL DIALYSIS	74.00	0	32,950	0	33.00
34.00	ASC (NON-DIAGNOSTIC PART)	75.00	0	55,140	0	34.00
36.00	CARDIAC REHABILITATION	76.97	0	10,634	0	36.00
37.00	CLINIC	90.00	0	13,170	0	37.00
38.00	EMERGENCY	91.00	0	216,393	0	38.00
	TOTALS		0	4,095,954		
I - OCCUPATIONAL THERAPY						
1.00	PHYSICAL THERAPY	66.00	0	1,429,314	0	1.00
	TOTALS		0	1,429,314		

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6

Date/Time Prepared:
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
J - MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	560	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,934	0		2.00
4.00	OPERATION OF PLANT	7.00	0	1,356	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	2,664	0		5.00
6.00	HOUSEKEEPING	9.00	0	4,044	0		6.00
7.00	DIETARY	10.00	0	1,259	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	662	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	100,040	0		9.00
10.00	PHARMACY	15.00	0	25,373	0		10.00
11.00	SOCIAL SERVICE	17.00	0	33	0		11.00
13.00	ADULTS & PEDIATRICS	30.00	0	1,253,664	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	487,220	0		14.00
15.00	NURSERY	43.00	0	39,749	0		15.00
16.00	SKILLED NURSING FACILITY	44.00	0	144,648	0		16.00
17.00	OPERATING ROOM	50.00	0	11,632,005	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	148,651	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	621,654	0		19.00
20.00	RADIOISOTOPE	56.00	0	4,351	0		20.00
21.00	ULTRASOUND	56.01	0	35,496	0		21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	3,778,366	0		22.00
23.00	LABORATORY	60.00	0	110	0		23.00
24.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	876,205	0		24.00
25.00	INTRAVENOUS THERAPY	64.00	0	144,130	0		25.00
26.00	RESPIRATORY THERAPY	65.00	0	242,411	0		26.00
27.00	PHYSICAL THERAPY	66.00	0	21,054	0		27.00
29.00	SPEECH PATHOLOGY	68.00	0	1,394	0		29.00
30.00	ELECTROCARDIOLOGY	69.00	0	19,056	0		30.00
31.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,967	0		31.00
32.00	RENAL DIALYSIS	74.00	0	172,081	0		32.00
33.00	ASC (NON-DISTINCT PART)	75.00	0	56,259	0		33.00
34.00	PULMONARY FUNCTION TESTING	76.00	0	1,779	0		34.00
35.00	CARDIAC REHABILITATION	76.97	0	4,060	0		35.00
36.00	CLINIC	90.00	0	856,831	0		36.00
37.00	EMERGENCY	91.00	0	615,211	0		37.00
38.00	NONREIMBURSABLE HHA	190.01	0	7	0		38.00
TOTALS			0	21,303,284			
K - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,979,669	0		1.00
TOTALS			0	8,979,669			
L - RADIOLOGY ADMINISTRATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	411,699	41,830	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			411,699	41,830			
M - MANAGEMENT INCENTIVES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	986,071	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
TOTALS			986,071	0			
N - ASSOCIATE BONUSES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	327,308	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
11.00		0.00	0	0	0		11.00

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6

Date/Time Prepared:
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
	6.00	7.00	8.00	9.00	10.00			
12.00		0.00	0	0	0	0		12.00
13.00		0.00	0	0	0	0		13.00
14.00		0.00	0	0	0	0		14.00
15.00		0.00	0	0	0	0		15.00
16.00		0.00	0	0	0	0		16.00
17.00		0.00	0	0	0	0		17.00
18.00		0.00	0	0	0	0		18.00
19.00		0.00	0	0	0	0		19.00
20.00		0.00	0	0	0	0		20.00
21.00		0.00	0	0	0	0		21.00
22.00		0.00	0	0	0	0		22.00
23.00		0.00	0	0	0	0		23.00
24.00		0.00	0	0	0	0		24.00
25.00		0.00	0	0	0	0		25.00
26.00		0.00	0	0	0	0		26.00
27.00		0.00	0	0	0	0		27.00
28.00		0.00	0	0	0	0		28.00
29.00		0.00	0	0	0	0		29.00
30.00		0.00	0	0	0	0		30.00
31.00		0.00	0	0	0	0		31.00
32.00		0.00	0	0	0	0		32.00
	TOTALS		327,308		0			
500.00	Grand Total : Decreases		3,066,679	51,923,806				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0250

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

Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	714,843	0	0	0	0	1.00
2.00	Land Improvements	5,478,279	18,887	0	18,887	0	2.00
3.00	Buildings and Fixtures	124,099,603	9,456,683	0	9,456,683	0	3.00
4.00	Building Improvements	948,868	2,359,324	0	2,359,324	0	4.00
5.00	Fixed Equipment	54,594,804	1,910,879	0	1,910,879	1,895,062	5.00
6.00	Movable Equipment	25,793	0	0	0	0	6.00
7.00	HIT designated Assets	802,434	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	186,664,624	13,745,773	0	13,745,773	1,895,062	8.00
9.00	Reconciling Items	-9,310,323	5,259,388	0	5,259,388	0	9.00
10.00	Total (line 8 minus line 9)	195,974,947	8,486,385	0	8,486,385	1,895,062	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	714,843	0				1.00
2.00	Land Improvements	5,497,166	3,364,192				2.00
3.00	Buildings and Fixtures	133,556,286	55,629,060				3.00
4.00	Building Improvements	3,308,192	269,880				4.00
5.00	Fixed Equipment	54,610,621	30,452,400				5.00
6.00	Movable Equipment	25,793	0				6.00
7.00	HIT designated Assets	802,434	631,147				7.00
8.00	Subtotal (sum of lines 1-7)	198,515,335	90,346,679				8.00
9.00	Reconciling Items	-4,050,935	0				9.00
10.00	Total (line 8 minus line 9)	202,566,270	90,346,679				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0250

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

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,849,871	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	4,849,871	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,849,871				1.00
3.00	Total (sum of lines 1-2)	0	4,849,871				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0250

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

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	10,635,821	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	10,635,821	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	10,635,821	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	10,635,821	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0250

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

Worksheet A-8

Date/Time Prepared:
5/29/2017 11:44 am

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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)				0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)				0*** Cost Center Deleted ***	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	-77,294		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	-5,980,443				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	-5,871,252				0	12.00
13.00 Laundry and linen service				0	0.00	0	13.00
14.00 Cafeteria-employees and guests				0	0.00	0	14.00
15.00 Rental of quarters to employee and others				0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients				0	0.00	0	16.00
17.00 Sale of drugs to other than patients				0	0.00	0	17.00
18.00 Sale of medical records and abstracts				0	0.00	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			0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)	A	-30,000		UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT				0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP				0*** Cost Center Deleted ***	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			0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		-638,375		ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest				0	0.00	0	32.00
33.00 OTHER NONALLOWABLE EXPENSES	A	-2,665		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0250

Period:
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To 12/31/2016

Worksheet A-8

Date/Time Prepared:
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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 OTHER NONALLOWABLE EXPENSES	A	-462,099	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 OTHER NONALLOWABLE EXPENSES	A	-8	OPERATION OF PLANT	7.00	0	33.02
33.03 OTHER NONALLOWABLE EXPENSES	A	-1,383	HOUSEKEEPING	9.00	0	33.03
33.04 OTHER NONALLOWABLE EXPENSES	A	-1,243	CAFETERIA	11.00	0	33.04
33.05 OTHER NONALLOWABLE EXPENSES	A	-1,852	NURSING ADMINISTRATION	13.00	0	33.05
33.06 OTHER NONALLOWABLE EXPENSES	A	-176	PHARMACY	15.00	0	33.06
33.07 OTHER NONALLOWABLE EXPENSES	A	-22,216	SOCIAL SERVICE	17.00	0	33.07
33.08 OTHER NONALLOWABLE EXPENSES	A	-654	ADULTS & PEDIATRICS	30.00	0	33.08
33.09 OTHER NONALLOWABLE EXPENSES	A	-14	INTENSIVE CARE UNIT	31.00	0	33.09
33.10 OTHER NONALLOWABLE EXPENSES	A	-437	OPERATING ROOM	50.00	0	33.10
33.11 OTHER NONALLOWABLE EXPENSES	A	-481	RESPIRATORY THERAPY	65.00	0	33.11
33.12 OTHER NONALLOWABLE EXPENSES	A	-43	ASC (NON-DISTINCT PART)	75.00	0	33.12
33.13 OTHER NONALLOWABLE EXPENSES	A	-478	CLINIC	90.00	0	33.13
33.14 OTHER NONALLOWABLE EXPENSES	A	-126,641	EMERGENCY	91.00	0	33.14
34.00		0		0.00	0	34.00
34.05		0		0.00	0	34.05
36.05 AHP FEE	A	-1,524,108	ADMINISTRATIVE & GENERAL	5.00	0	36.05
37.00 BOOKED DEPR TO MC	A	-400	NEW CAP REL COSTS-BLDG & FI XT	1.00	9	37.00
37.01		0		0.00	0	37.01
38.00		0		0.00	0	38.00
39.00		0		0.00	0	39.00
39.05		0		0.00	0	39.05
40.03		0		0.00	0	40.03
41.00 ADVERTISING COSTS	A	-7,819	ADMINISTRATIVE & GENERAL	5.00	0	41.00
45.01		0		0.00	0	45.01
45.02 BOOKED INTEREST EXPENSE	A	-1,536,405	INTEREST EXPENSE	113.00	0	45.02
45.06		0		0.00	0	45.06
45.07 HHA EXPENSES	A	-28,276	NONREIMBURSABLE HHA	190.01	0	45.07
45.10		0		0.00	0	45.10
45.15 PUBLIC AID ASSESSMENT	A	-8,444,164	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16		0		0.00	0	45.16
45.17		0		0.00	0	45.17
45.18 OTHER INCOME	B	-130	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.18
45.19 OTHER INCOME	B	-731,567	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.24 OTHER INCOME	B	-1,042	OPERATION OF PLANT	7.00	0	45.24
45.25 OTHER INCOME	B	-510,590	CAFETERIA	11.00	0	45.25
45.27 OTHER INCOME	B	-10	ADULTS & PEDIATRICS	30.00	0	45.27
45.28 OTHER INCOME	B	-11,000	RADIOLOGY-DIAGNOSTIC	54.00	0	45.28
45.30 OTHER INCOME	B	-13,102	RADIOISOTOPE	56.00	0	45.30
45.34 OTHER INCOME	B	-362,670	LABORATORY	60.00	0	45.34
45.35 OTHER INCOME	B	-210	PHYSICAL THERAPY	66.00	0	45.35
45.36 OTHER INCOME	B	-4,942	ELECTROCARDIOLOGY	69.00	0	45.36
45.37		0		0.00	0	45.37
45.38		0		0.00	0	45.38
45.39		0		0.00	0	45.39
45.40		0		0.00	0	45.40
45.41		0		0.00	0	45.41
45.42		0		0.00	0	45.42
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,394,189		0.00	0	50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0250

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2017 11:44 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	3,116,675	10,725,259 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION IT	3,888,470	7,072,349 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE PERSONNEL ALLOC	3,230,815	0 3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE DEPR	1,690,396	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	0		0	11,926,356	17,797,608 5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0250

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2017 11:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-7,608,584	0		1.00
2.00	-3,183,879	0		2.00
3.00	3,230,815	0		3.00
4.00	1,690,396	9		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-5,871,252			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0250

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2017 11:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,055,861	2,055,861	0	200,300	0	1.00
2.00	43.00	AGGREGATE-NURSERY	495,000	495,000	0	177,200	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,084,430	1,084,430	0	177,200	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	2,345,152	2,345,152	0	177,200	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,980,443	5,980,443	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,055,861		1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	495,000		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,084,430		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	2,345,152		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,980,443		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	10,635,821	10,635,821				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,875,194	17,258	16,892,452			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	28,491,490	1,101,582	1,574,020	31,167,092	31,167,092	5.00
7.00 00700	OPERATION OF PLANT	6,753,817	2,611,376	490,708	9,855,901	1,984,456	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	863,712	27,158	34,027	924,897	186,225	8.00
9.00 00900	HOUSEKEEPING	2,449,909	121,257	345,161	2,916,327	587,194	9.00
10.00 01000	DIETARY	1,878,084	195,080	239,133	2,312,297	465,574	10.00
11.00 01100	CAFETERIA	980,033	189,125	184,665	1,353,823	272,588	11.00
13.00 01300	NURSING ADMINISTRATION	6,018,158	100,849	1,295,340	7,414,347	1,492,857	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	714,769	67,577	102,457	884,803	178,152	14.00
15.00 01500	PHARMACY	3,070,713	103,813	692,590	3,867,116	778,632	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	15,630	109,372	0	125,002	25,169	16.00
17.00 01700	SOCIAL SERVICE	975,188	10,455	214,282	1,199,925	241,601	17.00
23.00 02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	20,880,683	2,156,498	4,458,346	27,495,527	5,536,118	30.00
31.00 03100	INTENSIVE CARE UNIT	5,324,601	372,532	851,715	6,548,848	1,318,591	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	551,188	44,681	116,796	712,665	143,493	43.00
44.00 04400	SKILLED NURSING FACILITY	2,442,913	396,460	517,408	3,356,781	675,878	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	6,300,686	611,843	1,103,532	8,016,061	1,614,010	50.00
53.00 05300	ANESTHESIOLOGY	296,554	10,588	32,185	339,327	68,322	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,279,309	603,425	1,112,727	6,995,461	1,408,515	54.00
56.00 05600	RADIOISOTOPE	946,127	71,282	71,779	1,089,188	219,305	56.00
56.01 05601	ULTRASOUND	749,858	0	160,016	909,874	183,200	56.01
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,904,956	99,393	343,191	2,347,540	472,670	59.00
60.00 06000	LABORATORY	6,607,078	252,996	0	6,860,074	1,381,255	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	496,576	29,064	0	525,640	105,836	62.00
64.00 06400	INTRAVENOUS THERAPY	418,702	5,373	83,070	507,145	102,112	64.00
65.00 06500	RESPIRATORY THERAPY	1,858,611	56,830	375,279	2,290,720	461,230	65.00
66.00 06600	PHYSICAL THERAPY	2,964,006	147,065	21,899	3,132,970	630,814	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,429,457	22,737	0	1,452,194	292,395	67.00
68.00 06800	SPEECH PATHOLOGY	310,150	5,373	67,419	382,942	77,104	68.00
69.00 06900	ELECTROCARDIOLOGY	1,254,380	23,081	257,294	1,534,755	309,018	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	119,930	23,770	21,400	165,100	33,242	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,323,615	0	0	12,323,615	2,481,323	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	8,979,669	0	0	8,979,669	1,808,029	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	13,937,170	0	0	13,937,170	2,806,207	73.00
74.00 07400	RENAL DIALYSIS	577,589	40,287	110,487	728,363	146,654	74.00
75.00 07500	ASC (NON-DISTINCT PART)	1,687,425	206,886	343,764	2,238,075	450,630	75.00
76.00 03560	PULMONARY FUNCTION TESTING	78,409	8,364	17,170	103,943	20,929	76.00
76.97 07697	CARDIAC REHABILITATION	400,584	79,541	85,227	565,352	113,832	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	2,400,306	201,142	490,455	3,091,903	622,545	90.00
91.00 09100	EMERGENCY	5,639,698	467,213	1,078,910	7,185,821	1,446,844	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	185,882,748	10,591,326	16,892,452	185,838,253	31,142,549	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	77,402	31,366	0	108,768	21,900	190.00
190.01	19001 NONREIMBURSABLE HHA	0	13,129	0	13,129	2,643	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	185,960,150	10,635,821	16,892,452	185,960,150	31,167,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	11,840,357				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,565	1,157,687			8.00
9.00	00900	HOUSEKEEPING	207,907	0	3,711,428		9.00
10.00	01000	DIETARY	334,485	0	107,149	3,219,505	10.00
11.00	01100	CAFETERIA	324,273	0	103,878	0	11.00
13.00	01300	NURSING ADMINISTRATION	172,916	0	55,392	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115,867	0	37,117	0	14.00
15.00	01500	PHARMACY	177,999	0	57,020	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,529	0	60,073	0	16.00
17.00	01700	SOCIAL SERVICE	17,927	0	5,743	0	17.00
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,697,534	775,113	1,184,473	2,155,574	30.00
31.00	03100	INTENSIVE CARE UNIT	638,744	128,000	204,615	355,966	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	76,609	50,714	24,541	141,035	43.00
44.00	04400	SKILLED NURSING FACILITY	679,771	203,860	217,758	566,930	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,049,066	0	336,058	0	50.00
53.00	05300	ANESTHESIOLOGY	18,154	0	5,815	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,034,634	0	331,435	0	54.00
56.00	05600	RADIOISOTOPE	122,221	0	39,152	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	170,419	0	54,592	0	59.00
60.00	06000	LABORATORY	433,787	0	138,959	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	49,832	0	15,963	0	62.00
64.00	06400	INTRAVENOUS THERAPY	9,213	0	2,951	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,441	0	31,214	0	65.00
66.00	06600	PHYSICAL THERAPY	252,157	0	80,776	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,985	0	12,489	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,213	0	2,951	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,575	0	12,678	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	40,755	0	13,056	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	69,075	0	22,128	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	354,726	0	113,633	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	14,342	0	4,594	0	76.00
76.97	07697	CARDIAC REHABILITATION	136,381	0	43,688	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	344,878	0	110,478	0	90.00
91.00	09100	EMERGENCY	801,085	0	256,620	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,764,065	1,157,687	3,686,989	3,219,505	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,781	0	17,228	0	190.00
190.01	19001	NONREIMBURSABLE HHA	22,511	0	7,211	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	11,840,357	1,157,687	3,711,428	3,219,505	2,054,562	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	9,325,273					13.00
14.00	01400	0	1,230,949				14.00
15.00	01500	0	45,835	5,028,063			15.00
16.00	01600	0	0	0	397,773		16.00
17.00	01700	197,430	1,143	0	0	1,695,160	17.00
23.00	02301	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,094,986	312,019	54,518	53,676	1,134,970	30.00
31.00	03100	800,584	32,528	13,513	11,834	187,426	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	111,083	1,807	223	1,269	74,259	43.00
44.00	04400	486,452	45,435	2,885	4,019	298,505	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,004,601	454,758	19,147	46,717	0	50.00
53.00	05300	32,603	22,317	36,333	11,106	0	53.00
54.00	05400	97,035	45,423	14,670	55,429	0	54.00
56.00	05600	0	1,969	227,062	4,078	0	56.00
56.01	05601	0	16,104	9	6,292	0	56.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	264,999	25,706	1,491	9,523	0	59.00
60.00	06000	0	0	0	29,660	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	1,930	0	62.00
64.00	06400	81,321	1,548	14,424	567	0	64.00
65.00	06500	24,433	8,001	177	5,458	0	65.00
66.00	06600	21,984	8,579	2	7,383	0	66.00
67.00	06700	0	47	20	3,646	0	67.00
68.00	06800	59,656	2,368	0	821	0	68.00
69.00	06900	199,746	10,138	962	8,407	0	69.00
70.00	07000	20,288	38,447	0	425	0	70.00
71.00	07100	0	0	0	10,153	0	71.00
72.00	07200	0	0	0	13,144	0	72.00
73.00	07300	0	0	4,542,580	50,088	0	73.00
74.00	07400	100,738	18,772	190	1,725	0	74.00
75.00	07500	324,240	26,547	23,440	4,542	0	75.00
76.00	03560	0	584	0	112	0	76.00
76.97	07697	37,993	6,995	0	458	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	281,441	51,376	5,025	7,617	0	90.00
91.00	09100	1,083,660	52,491	71,392	47,694	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		9,325,273	1,230,937	5,028,063	397,773	1,695,160	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	12	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,325,273	1,230,949	5,028,063	397,773	1,695,160	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
23.00	02301	PARAMEDICAL ED PRGM	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	47,147,641	0	47,147,641
31.00	03100	INTENSIVE CARE UNIT	0	10,365,421	0	10,365,421
32.00	03200	CORONARY CARE UNIT	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	0	1,354,808	0	1,354,808
44.00	04400	SKILLED NURSING FACILITY	0	6,614,072	0	6,614,072
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,702,080	0	12,702,080
53.00	05300	ANESTHESIOLOGY	0	538,692	0	538,692
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,145,611	0	10,145,611
56.00	05600	RADIOISOTOPE	0	1,713,490	0	1,713,490
56.01	05601	ULTRASOUND	0	1,138,921	0	1,138,921
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	3,397,216	0	3,397,216
60.00	06000	LABORATORY	0	8,843,735	0	8,843,735
60.01	06001	BLOOD LABORATORY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	699,201	0	699,201
64.00	06400	INTRAVENOUS THERAPY	0	731,450	0	731,450
65.00	06500	RESPIRATORY THERAPY	0	2,973,650	0	2,973,650
66.00	06600	PHYSICAL THERAPY	0	4,137,873	0	4,137,873
67.00	06700	OCCUPATIONAL THERAPY	0	1,799,776	0	1,799,776
68.00	06800	SPEECH PATHOLOGY	0	544,932	0	544,932
69.00	06900	ELECTROCARDIOLOGY	0	2,152,971	0	2,152,971
70.00	07000	ELECTROENCEPHALOGRAPHY	0	314,448	0	314,448
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,815,091	0	14,815,091
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,800,842	0	10,800,842
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,336,045	0	21,336,045
74.00	07400	RENAL DIALYSIS	0	1,103,831	0	1,103,831
75.00	07500	ASC (NON-DISTINCT PART)	0	3,586,193	0	3,586,193
76.00	03560	PULMONARY FUNCTION TESTING	0	147,019	0	147,019
76.97	07697	CARDIAC REHABILITATION	0	917,184	0	917,184
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	4,587,112	0	4,587,112
91.00	09100	EMERGENCY	0	11,103,662	0	11,103,662
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
93.00	04950	SLEEP LAB	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	185,712,967	0	185,712,967

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

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Part I
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Cost Center Description			PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	201,689	0	201,689		190.00
190.01	19001	NONREIMBURSABLE HHA	0	45,494	0	45,494		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	FUND RAISING	0	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	185,960,150	0	185,960,150		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0250

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

Worksheet B Part II Date/Time Prepared: 5/29/2017 11:44 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	77	17,258	17,335	17,335		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	292,418	1,101,582	1,394,000	1,618	1,395,618	5.00
7.00 00700	OPERATION OF PLANT	0	2,611,376	2,611,376	504	88,861	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	27,158	27,158	35	8,339	8.00
9.00 00900	HOUSEKEEPING	116	121,257	121,373	355	26,294	9.00
10.00 01000	DIETARY	1,630	195,080	196,710	246	20,848	10.00
11.00 01100	CAFETERIA	0	189,125	189,125	190	12,206	11.00
13.00 01300	NURSING ADMINISTRATION	157	100,849	101,006	1,331	66,848	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	184,451	67,577	252,028	105	7,977	14.00
15.00 01500	PHARMACY	68,399	103,813	172,212	712	34,866	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	109,372	109,372	0	1,127	16.00
17.00 01700	SOCIAL SERVICE	0	10,455	10,455	220	10,819	17.00
23.00 02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	4,658	2,156,498	2,161,156	4,555	247,904	30.00
31.00 03100	INTENSIVE CARE UNIT	0	372,532	372,532	875	59,044	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	104	44,681	44,785	120	6,425	43.00
44.00 04400	SKILLED NURSING FACILITY	200	396,460	396,660	532	30,265	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	3,314	611,843	615,157	1,134	72,273	50.00
53.00 05300	ANESTHESIOLOGY	0	10,588	10,588	33	3,059	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,000	603,425	607,425	1,144	63,071	54.00
56.00 05600	RADIOISOTOPE	0	71,282	71,282	74	9,820	56.00
56.01 05601	ULTRASOUND	200	0	200	164	8,203	56.01
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	99,393	99,393	353	21,165	59.00
60.00 06000	LABORATORY	0	252,996	252,996	0	61,850	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	29,064	29,064	0	4,739	62.00
64.00 06400	INTRAVENOUS THERAPY	0	5,373	5,373	85	4,572	64.00
65.00 06500	RESPIRATORY THERAPY	41,341	56,830	98,171	386	20,653	65.00
66.00 06600	PHYSICAL THERAPY	251	147,065	147,316	23	28,247	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	22,737	22,737	0	13,093	67.00
68.00 06800	SPEECH PATHOLOGY	0	5,373	5,373	69	3,453	68.00
69.00 06900	ELECTROCARDIOLOGY	0	23,081	23,081	264	13,837	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	23,770	23,770	22	1,489	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	111,110	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	80,961	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	125,658	73.00
74.00 07400	RENAL DIALYSIS	0	40,287	40,287	114	6,567	74.00
75.00 07500	ASC (NON-DISTINCT PART)	375	206,886	207,261	353	20,178	75.00
76.00 03560	PULMONARY FUNCTION TESTING	0	8,364	8,364	18	937	76.00
76.97 07697	CARDIAC REHABILITATION	0	79,541	79,541	88	5,097	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	201,142	201,142	504	27,877	90.00
91.00 09100	EMERGENCY	0	467,213	467,213	1,109	64,787	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	601,691	10,591,326	11,193,017	17,335	1,394,519	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0250

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,366	31,366	0	981	190.00
190.01 19001	NONREIMBURSABLE HHA	0	13,129	13,129	0	118	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	FUND RAISING	0	0	0	0	0	194.00
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)	601,691	10,635,821	11,237,512	17,335	1,395,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/29/2017 11:44 am		
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
			7.00	8.00	9.00	10.00	11.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	2,700,741				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,621	46,153			8.00
9.00	00900	HOUSEKEEPING	47,423	0	195,445		9.00
10.00	01000	DIETARY	76,295	0	5,643	299,742	10.00
11.00	01100	CAFETERIA	73,966	0	5,470	0	280,957
13.00	01300	NURSING ADMINISTRATION	39,441	0	2,917	0	25,950
14.00	01400	CENTRAL SERVICES & SUPPLY	26,429	0	1,955	0	2,053
15.00	01500	PHARMACY	40,601	0	3,003	0	13,875
16.00	01600	MEDICAL RECORDS & LIBRARY	42,775	0	3,163	0	0
17.00	01700	SOCIAL SERVICE	4,089	0	302	0	4,293
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	843,395	30,901	62,373	200,688	89,308
31.00	03100	INTENSIVE CARE UNIT	145,695	5,103	10,775	33,141	17,063
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	17,474	2,022	1,292	13,131	2,340
44.00	04400	SKILLED NURSING FACILITY	155,053	8,127	11,467	52,782	10,365
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	239,288	0	17,697	0	22,108
53.00	05300	ANESTHESIOLOGY	4,141	0	306	0	645
54.00	05400	RADIOLOGY-DIAGNOSTIC	235,996	0	17,453	0	22,292
56.00	05600	RADIOISOTOPE	27,878	0	2,062	0	1,438
56.01	05601	ULTRASOUND	0	0	0	0	3,206
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	38,872	0	2,875	0	6,875
60.00	06000	LABORATORY	98,945	0	7,318	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,367	0	841	0	0
64.00	06400	INTRAVENOUS THERAPY	2,101	0	155	0	1,664
65.00	06500	RESPIRATORY THERAPY	22,226	0	1,644	0	7,518
66.00	06600	PHYSICAL THERAPY	57,516	0	4,254	0	439
67.00	06700	OCCUPATIONAL THERAPY	8,892	0	658	0	0
68.00	06800	SPEECH PATHOLOGY	2,101	0	155	0	1,351
69.00	06900	ELECTROCARDIOLOGY	9,027	0	668	0	5,154
70.00	07000	ELECTROENCEPHALOGRAPHY	9,296	0	688	0	429
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	15,756	0	1,165	0	2,213
75.00	07500	ASC (NON-DISTINCT PART)	80,912	0	5,984	0	6,887
76.00	03560	PULMONARY FUNCTION TESTING	3,271	0	242	0	344
76.97	07697	CARDIAC REHABILITATION	31,108	0	2,301	0	1,707
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	78,665	0	5,818	0	9,826
91.00	09100	EMERGENCY	182,724	0	13,514	0	21,614
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,683,339	46,153	194,158	299,742	280,957
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,267	0	907	0	0
190.01	19001	NONREIMBURSABLE HHA	5,135	0	380	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0250			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
			7.00	8.00	9.00	10.00	11.00		
194.00	07950	FUND RAISING	0	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,700,741	46,153	195,445	299,742	280,957		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0250		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	237,493				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	290,547			14.00
15.00	01500	PHARMACY	0	10,819	276,088		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	156,437	16.00
17.00	01700	SOCIAL SERVICE	5,028	270	0	0	35,476
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	104,299	73,647	2,994	21,066	23,753
31.00	03100	INTENSIVE CARE UNIT	20,388	7,678	742	4,644	3,922
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	2,829	426	12	498	1,554
44.00	04400	SKILLED NURSING FACILITY	12,388	10,724	158	1,577	6,247
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,583	107,339	1,051	18,335	0
53.00	05300	ANESTHESIOLOGY	830	5,268	1,995	4,359	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,471	10,721	806	22,080	0
56.00	05600	RADIOISOTOPE	0	465	12,468	1,601	0
56.01	05601	ULTRASOUND	0	3,801	0	2,469	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	6,748	6,067	82	3,737	0
60.00	06000	LABORATORY	0	0	0	11,640	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	757	0
64.00	06400	INTRAVENOUS THERAPY	2,071	365	792	223	0
65.00	06500	RESPIRATORY THERAPY	622	1,889	10	2,142	0
66.00	06600	PHYSICAL THERAPY	560	2,025	0	2,898	0
67.00	06700	OCCUPATIONAL THERAPY	0	11	1	1,431	0
68.00	06800	SPEECH PATHOLOGY	1,519	559	0	322	0
69.00	06900	ELECTROCARDIOLOGY	5,087	2,393	53	3,299	0
70.00	07000	ELECTROENCEPHALOGRAPHY	517	9,075	0	167	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,985	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,158	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	249,431	19,658	0
74.00	07400	RENAL DIALYSIS	2,565	4,431	10	677	0
75.00	07500	ASC (NON-DISTINCT PART)	8,257	6,266	1,287	1,782	0
76.00	03560	PULMONARY FUNCTION TESTING	0	138	0	44	0
76.97	07697	CARDIAC REHABILITATION	968	1,651	0	180	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	7,167	12,126	276	2,990	0
91.00	09100	EMERGENCY	27,596	12,390	3,920	18,718	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	237,493	290,544	276,088	156,437	35,476
NONREIMBURSABLE COST CENTERS							
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	3	0	0	0
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0250

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	237,493	290,547	276,088	156,437	35,476	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/29/2017 11:44 am
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Cost Center Description		PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE				17.00	
23.00	02301	PARAMEDICAL ED PRGM	0			23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,866,039	0	3,866,039	30.00	
31.00	03100	INTENSIVE CARE UNIT	681,602	0	681,602	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	42.00	
43.00	04300	NURSERY	92,908	0	92,908	43.00	
44.00	04400	SKILLED NURSING FACILITY	696,345	0	696,345	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,119,965	0	1,119,965	50.00	
53.00	05300	ANESTHESIOLOGY	31,224	0	31,224	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	983,459	0	983,459	54.00	
56.00	05600	RADIOISOTOPE	127,088	0	127,088	56.00	
56.01	05601	ULTRASOUND	18,043	0	18,043	56.01	
57.00	05700	CT SCAN	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	186,167	0	186,167	59.00	
60.00	06000	LABORATORY	432,749	0	432,749	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,768	0	46,768	62.00	
64.00	06400	INTRAVENOUS THERAPY	17,401	0	17,401	64.00	
65.00	06500	RESPIRATORY THERAPY	155,261	0	155,261	65.00	
66.00	06600	PHYSICAL THERAPY	243,278	0	243,278	66.00	
67.00	06700	OCCUPATIONAL THERAPY	46,823	0	46,823	67.00	
68.00	06800	SPEECH PATHOLOGY	14,902	0	14,902	68.00	
69.00	06900	ELECTROCARDIOLOGY	62,863	0	62,863	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	45,453	0	45,453	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,095	0	115,095	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	86,119	0	86,119	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	394,747	0	394,747	73.00	
74.00	07400	RENAL DIALYSIS	73,785	0	73,785	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	339,167	0	339,167	75.00	
76.00	03560	PULMONARY FUNCTION TESTING	13,358	0	13,358	76.00	
76.97	07697	CARDIAC REHABILITATION	122,641	0	122,641	76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00	
90.00	09000	CLINIC	346,391	0	346,391	90.00	
91.00	09100	EMERGENCY	813,585	0	813,585	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00	
93.00	04950	SLEEP LAB	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	99.10	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	111.00	
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	112.00	
113.00	11300	INTEREST EXPENSE	0	0	0	113.00	
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	114.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11,173,226	0	11,173,226	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0250

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description			PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		45,524	0	45,524	190.00
190.01	19001	NONREIMBURSABLE HHA		18,762	0	18,762	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0	0	192.00
194.00	07950	FUND RAISING		0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	11,237,512	0	11,237,512	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	401,814					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	652	71,455,730				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	41,617	6,658,178	-31,167,092	154,793,058		5.00
7.00 00700 OPERATION OF PLANT	98,656	2,075,718	0	9,855,901	260,889	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,026	143,934	0	924,897	1,026	8.00
9.00 00900 HOUSEKEEPING	4,581	1,460,048	0	2,916,327	4,581	9.00
10.00 01000 DIETARY	7,370	1,011,543	0	2,312,297	7,370	10.00
11.00 01100 CAFETERIA	7,145	781,141	0	1,353,823	7,145	11.00
13.00 01300 NURSING ADMINISTRATION	3,810	5,479,351	0	7,414,347	3,810	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2,553	433,400	0	884,803	2,553	14.00
15.00 01500 PHARMACY	3,922	2,929,687	0	3,867,116	3,922	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	4,132	0	0	125,002	4,132	16.00
17.00 01700 SOCIAL SERVICE	395	906,424	0	1,199,925	395	17.00
23.00 02301 PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	81,471	18,858,873	0	27,495,527	81,471	30.00
31.00 03100 INTENSIVE CARE UNIT	14,074	3,602,794	0	6,548,848	14,074	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	1,688	494,053	0	712,665	1,688	43.00
44.00 04400 SKILLED NURSING FACILITY	14,978	2,188,660	0	3,356,781	14,978	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	23,115	4,667,990	0	8,016,061	23,115	50.00
53.00 05300 ANESTHESIOLOGY	400	136,146	0	339,327	400	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	22,797	4,706,886	0	6,995,461	22,797	54.00
56.00 05600 RADIOISOTOPE	2,693	303,629	0	1,089,188	2,693	56.00
56.01 05601 ULTRASOUND	0	676,877	0	909,874	0	56.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	3,755	1,451,713	0	2,347,540	3,755	59.00
60.00 06000 LABORATORY	9,558	0	0	6,860,074	9,558	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,098	0	0	525,640	1,098	62.00
64.00 06400 INTRAVENOUS THERAPY	203	351,391	0	507,145	203	64.00
65.00 06500 RESPIRATORY THERAPY	2,147	1,587,448	0	2,290,720	2,147	65.00
66.00 06600 PHYSICAL THERAPY	5,556	92,635	0	3,132,970	5,556	66.00
67.00 06700 OCCUPATIONAL THERAPY	859	0	0	1,452,194	859	67.00
68.00 06800 SPEECH PATHOLOGY	203	285,185	0	382,942	203	68.00
69.00 06900 ELECTROCARDIOLOGY	872	1,088,365	0	1,534,755	872	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	898	90,524	0	165,100	898	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,323,615	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,979,669	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	13,937,170	0	73.00
74.00 07400 RENAL DIALYSIS	1,522	467,367	0	728,363	1,522	74.00
75.00 07500 ASC (NON-DISTINCT PART)	7,816	1,454,136	0	2,238,075	7,816	75.00
76.00 03560 PULMONARY FUNCTION TESTING	316	72,632	0	103,943	316	76.00
76.97 07697 CARDIAC REHABILITATION	3,005	360,514	0	565,352	3,005	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	7,599	2,074,647	0	3,091,903	7,599	90.00
91.00 09100 EMERGENCY	17,651	4,563,841	0	7,185,821	17,651	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04950 SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600 OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00		5A	5.00	7.00		
118.00	SUBTOTALS (SUM OF LINES 1-117)		400,133	71,455,730	-31,167,092	154,671,161	259,208	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,185	0	0	108,768	1,185	190.00
190.01	19001	NONREIMBURSABLE HHA	496	0	0	13,129	496	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,635,821	16,892,452		31,167,092	11,840,357	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.469513	0.236404		0.201347	45.384654	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		17,335		1,395,618	2,700,741	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000243		0.009016	10.352069	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,933				8.00
9.00	00900	HOUSEKEEPING	0	255,282			9.00
10.00	01000	DIETARY	0	7,370	51,933		10.00
11.00	01100	CAFETERIA	0	7,145	0	59,325,168	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,810	0	5,479,351	41,221,323
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,553	0	433,400	0
15.00	01500	PHARMACY	0	3,922	0	2,929,687	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,132	0	0	0
17.00	01700	SOCIAL SERVICE	0	395	0	906,424	872,720
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,771	81,471	34,771	18,858,873	18,101,379
31.00	03100	INTENSIVE CARE UNIT	5,742	14,074	5,742	3,602,794	3,538,901
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	2,275	1,688	2,275	494,053	491,030
44.00	04400	SKILLED NURSING FACILITY	9,145	14,978	9,145	2,188,660	2,150,310
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	23,115	0	4,667,990	4,440,734
53.00	05300	ANESTHESIOLOGY	0	400	0	136,146	144,117
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,797	0	4,706,886	428,932
56.00	05600	RADIOISOTOPE	0	2,693	0	303,629	0
56.01	05601	ULTRASOUND	0	0	0	676,877	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	3,755	0	1,451,713	1,171,400
60.00	06000	LABORATORY	0	9,558	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,098	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	203	0	351,391	359,473
65.00	06500	RESPIRATORY THERAPY	0	2,147	0	1,587,448	108,005
66.00	06600	PHYSICAL THERAPY	0	5,556	0	92,635	97,178
67.00	06700	OCCUPATIONAL THERAPY	0	859	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	203	0	285,185	263,704
69.00	06900	ELECTROCARDIOLOGY	0	872	0	1,088,365	882,957
70.00	07000	ELECTROENCEPHALOGRAPHY	0	898	0	90,524	89,682
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	1,522	0	467,367	445,301
75.00	07500	ASC (NON-DISTINCT PART)	0	7,816	0	1,454,136	1,433,268
76.00	03560	PULMONARY FUNCTION TESTING	0	316	0	72,632	0
76.97	07697	CARDIAC REHABILITATION	0	3,005	0	360,514	167,943
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	7,599	0	2,074,647	1,244,083
91.00	09100	EMERGENCY	0	17,651	0	4,563,841	4,790,206
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,933	253,601	51,933	59,325,168	41,221,323

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
		8.00	9.00	10.00	11.00	13.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,185	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	496	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,157,687	3,711,428	3,219,505	2,054,562	9,325,273
203.00		Unit cost multiplier (Wkst. B, Part I)	22.291934	14.538542	61.993434	0.034632	0.226224
204.00		Cost to be allocated (per Wkst. B, Part II)	46,153	195,445	299,742	280,957	237,493
205.00		Unit cost multiplier (Wkst. B, Part II)	0.888703	0.765604	5.771706	0.004736	0.005761

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PARAMEDICAL ED PRGM (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	1,479,062					14.00
15.00	01500	55,074	13,857,829				15.00
16.00	01600	0	0	881,844,337			16.00
17.00	01700	1,373	0	0	51,933		17.00
23.00	02301	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	374,910	150,257	119,015,475	34,771	0	30.00
31.00	03100	39,085	37,243	26,239,544	5,742	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	2,171	614	2,814,274	2,275	0	43.00
44.00	04400	54,593	7,951	8,911,680	9,145	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	546,422	52,770	103,585,972	0	0	50.00
53.00	05300	26,815	100,136	24,624,821	0	0	53.00
54.00	05400	54,578	40,432	122,765,451	0	0	54.00
56.00	05600	2,366	625,804	9,043,083	0	0	56.00
56.01	05601	19,350	24	13,950,815	0	0	56.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	30,887	4,110	21,114,677	0	0	59.00
60.00	06000	0	0	65,765,182	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	4,279,532	0	0	62.00
64.00	06400	1,860	39,754	1,258,131	0	0	64.00
65.00	06500	9,614	487	12,101,991	0	0	65.00
66.00	06600	10,308	6	16,370,205	0	0	66.00
67.00	06700	57	54	8,084,991	0	0	67.00
68.00	06800	2,845	0	1,819,766	0	0	68.00
69.00	06900	12,181	2,650	18,640,947	0	0	69.00
70.00	07000	46,196	0	942,024	0	0	70.00
71.00	07100	0	0	22,511,869	0	0	71.00
72.00	07200	0	0	29,143,707	0	0	72.00
73.00	07300	0	12,519,798	111,060,823	0	0	73.00
74.00	07400	22,556	523	3,823,998	0	0	74.00
75.00	07500	31,898	64,604	10,070,064	0	0	75.00
76.00	03560	702	0	248,989	0	0	76.00
76.97	07697	8,405	0	1,015,317	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	61,731	13,849	16,890,207	0	0	90.00
91.00	09100	63,071	196,763	105,750,802	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		1,479,048	13,857,829	881,844,337	51,933	0	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PARAMEDICAL ED PRGM (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	23.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14	0	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,230,949	5,028,063	397,773	1,695,160	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.832250	0.362832	0.000451	32.641288	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	290,547	276,088	156,437	35,476	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.196440	0.019923	0.000177	0.683111	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2017 11:44 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	47,147,641		47,147,641	0	47,147,641	30.00
31.00	03100 INTENSIVE CARE UNIT	10,365,421		10,365,421	0	10,365,421	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,354,808		1,354,808	0	1,354,808	43.00
44.00	04400 SKILLED NURSING FACILITY	6,614,072		6,614,072	0	6,614,072	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,702,080		12,702,080	0	12,702,080	50.00
53.00	05300 ANESTHESIOLOGY	538,692		538,692	0	538,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,145,611		10,145,611	0	10,145,611	54.00
56.00	05600 RADIOISOTOPE	1,713,490		1,713,490	0	1,713,490	56.00
56.01	05601 ULTRASOUND	1,138,921		1,138,921	0	1,138,921	56.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,397,216		3,397,216	0	3,397,216	59.00
60.00	06000 LABORATORY	8,843,735		8,843,735	0	8,843,735	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	699,201		699,201	0	699,201	62.00
64.00	06400 INTRAVENOUS THERAPY	731,450		731,450	0	731,450	64.00
65.00	06500 RESPIRATORY THERAPY	2,973,650	0	2,973,650	0	2,973,650	65.00
66.00	06600 PHYSICAL THERAPY	4,137,873	0	4,137,873	0	4,137,873	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,799,776	0	1,799,776	0	1,799,776	67.00
68.00	06800 SPEECH PATHOLOGY	544,932	0	544,932	0	544,932	68.00
69.00	06900 ELECTROCARDIOLOGY	2,152,971		2,152,971	0	2,152,971	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	314,448		314,448	0	314,448	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14,815,091		14,815,091	0	14,815,091	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,800,842		10,800,842	0	10,800,842	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,336,045		21,336,045	0	21,336,045	73.00
74.00	07400 RENAL DIALYSIS	1,103,831		1,103,831	0	1,103,831	74.00
75.00	07500 ASC (NON-DISTINCT PART)	3,586,193		3,586,193	0	3,586,193	75.00
76.00	03560 PULMONARY FUNCTION TESTING	147,019		147,019	0	147,019	76.00
76.97	07697 CARDIAC REHABILITATION	917,184		917,184	0	917,184	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	4,587,112		4,587,112	0	4,587,112	90.00
91.00	09100 EMERGENCY	11,103,662		11,103,662	0	11,103,662	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,316,998		10,316,998	0	10,316,998	92.00
93.00	04950 SLEEP LAB	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0		0	0	0	112.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
200.00	Subtotal (see instructions)	196,029,965	0	196,029,965	0	196,029,965	200.00
201.00	Less Observation Beds	10,316,998		10,316,998	0	10,316,998	201.00
202.00	Total (see instructions)	185,712,967	0	185,712,967	0	185,712,967	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2017 11:44 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	86,576,968		86,576,968		30.00
31.00	03100	INTENSIVE CARE UNIT	26,239,544		26,239,544		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,814,274		2,814,274		43.00
44.00	04400	SKILLED NURSING FACILITY	8,911,680		8,911,680		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	40,556,777	63,029,195	103,585,972	0.122624	50.00
53.00	05300	ANESTHESIOLOGY	8,399,664	16,225,157	24,624,821	0.021876	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,759,191	87,006,260	122,765,451	0.082642	54.00
56.00	05600	RADIO SOTOPE	2,795,152	6,247,931	9,043,083	0.189481	56.00
56.01	05601	ULTRASOUND	2,037,046	11,913,769	13,950,815	0.081638	56.01
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,075,638	10,039,039	21,114,677	0.160894	59.00
60.00	06000	LABORATORY	36,978,234	28,786,948	65,765,182	0.134474	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,203,930	1,075,602	4,279,532	0.163383	62.00
64.00	06400	INTRAVENOUS THERAPY	1,138,784	119,347	1,258,131	0.581378	64.00
65.00	06500	RESPIRATORY THERAPY	10,132,456	1,969,535	12,101,991	0.245716	65.00
66.00	06600	PHYSICAL THERAPY	8,078,435	8,291,770	16,370,205	0.252769	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,166,288	2,918,703	8,084,991	0.222607	67.00
68.00	06800	SPEECH PATHOLOGY	1,373,070	446,696	1,819,766	0.299452	68.00
69.00	06900	ELECTROCARDIOLOGY	7,345,433	11,295,514	18,640,947	0.115497	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	371,414	570,610	942,024	0.333800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,023,538	8,488,331	22,511,869	0.658101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,439,797	13,703,910	29,143,707	0.370606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,656,504	46,404,319	111,060,823	0.192111	73.00
74.00	07400	RENAL DIALYSIS	3,202,942	621,056	3,823,998	0.288659	74.00
75.00	07500	ASC (NON-DISTINCT PART)	646,265	9,423,799	10,070,064	0.356124	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	248,989	248,989	0.590464	76.00
76.97	07697	CARDIAC REHABILITATION	21,417	993,900	1,015,317	0.903347	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	111,144	16,779,063	16,890,207	0.271584	90.00
91.00	09100	EMERGENCY	23,235,407	82,515,395	105,750,802	0.104998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,707,528	19,730,979	32,438,507	0.318048	92.00
93.00	04950	SLEEP LAB	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	432,998,520	448,845,817	881,844,337		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	432,998,520	448,845,817	881,844,337		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/29/2017 11:44 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.122624		50.00
53.00	05300	ANESTHESIOLOGY	0.021876		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082642		54.00
56.00	05600	RADIOISOTOPE	0.189481		56.00
56.01	05601	ULTRASOUND	0.081638		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160894		59.00
60.00	06000	LABORATORY	0.134474		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.163383		62.00
64.00	06400	INTRAVENOUS THERAPY	0.581378		64.00
65.00	06500	RESPIRATORY THERAPY	0.245716		65.00
66.00	06600	PHYSICAL THERAPY	0.252769		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.222607		67.00
68.00	06800	SPEECH PATHOLOGY	0.299452		68.00
69.00	06900	ELECTROCARDIOLOGY	0.115497		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333800		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.658101		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.370606		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192111		73.00
74.00	07400	RENAL DIALYSIS	0.288659		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.356124		75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.590464		76.00
76.97	07697	CARDIAC REHABILITATION	0.903347		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.271584		90.00
91.00	09100	EMERGENCY	0.104998		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318048		92.00
93.00	04950	SLEEP LAB	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF			112.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2017 11:44 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	47,147,641		47,147,641	0	47,147,641	30.00
31.00	03100 INTENSIVE CARE UNIT	10,365,421		10,365,421	0	10,365,421	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,354,808		1,354,808	0	1,354,808	43.00
44.00	04400 SKILLED NURSING FACILITY	6,614,072		6,614,072	0	6,614,072	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,702,080		12,702,080	0	12,702,080	50.00
53.00	05300 ANESTHESIOLOGY	538,692		538,692	0	538,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,145,611		10,145,611	0	10,145,611	54.00
56.00	05600 RADIOISOTOPE	1,713,490		1,713,490	0	1,713,490	56.00
56.01	05601 ULTRASOUND	1,138,921		1,138,921	0	1,138,921	56.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,397,216		3,397,216	0	3,397,216	59.00
60.00	06000 LABORATORY	8,843,735		8,843,735	0	8,843,735	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	699,201		699,201	0	699,201	62.00
64.00	06400 INTRAVENOUS THERAPY	731,450		731,450	0	731,450	64.00
65.00	06500 RESPIRATORY THERAPY	2,973,650	0	2,973,650	0	2,973,650	65.00
66.00	06600 PHYSICAL THERAPY	4,137,873	0	4,137,873	0	4,137,873	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,799,776	0	1,799,776	0	1,799,776	67.00
68.00	06800 SPEECH PATHOLOGY	544,932	0	544,932	0	544,932	68.00
69.00	06900 ELECTROCARDIOLOGY	2,152,971		2,152,971	0	2,152,971	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	314,448		314,448	0	314,448	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14,815,091		14,815,091	0	14,815,091	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,800,842		10,800,842	0	10,800,842	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,336,045		21,336,045	0	21,336,045	73.00
74.00	07400 RENAL DIALYSIS	1,103,831		1,103,831	0	1,103,831	74.00
75.00	07500 ASC (NON-DISTINCT PART)	3,586,193		3,586,193	0	3,586,193	75.00
76.00	03560 PULMONARY FUNCTION TESTING	147,019		147,019	0	147,019	76.00
76.97	07697 CARDIAC REHABILITATION	917,184		917,184	0	917,184	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	4,587,112		4,587,112	0	4,587,112	90.00
91.00	09100 EMERGENCY	11,103,662		11,103,662	0	11,103,662	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,316,998		10,316,998	0	10,316,998	92.00
93.00	04950 SLEEP LAB	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0		0	0	0	112.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
200.00	Subtotal (see instructions)	196,029,965	0	196,029,965	0	196,029,965	200.00
201.00	Less Observation Beds	10,316,998		10,316,998	0	10,316,998	201.00
202.00	Total (see instructions)	185,712,967	0	185,712,967	0	185,712,967	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2017 11:44 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	86,576,968		86,576,968		30.00
31.00	03100	INTENSIVE CARE UNIT	26,239,544		26,239,544		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,814,274		2,814,274		43.00
44.00	04400	SKILLED NURSING FACILITY	8,911,680		8,911,680		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	40,556,777	63,029,195	103,585,972	0.122624	50.00
53.00	05300	ANESTHESIOLOGY	8,399,664	16,225,157	24,624,821	0.021876	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,759,191	87,006,260	122,765,451	0.082642	54.00
56.00	05600	RADIOISOTOPE	2,795,152	6,247,931	9,043,083	0.189481	56.00
56.01	05601	ULTRASOUND	2,037,046	11,913,769	13,950,815	0.081638	56.01
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,075,638	10,039,039	21,114,677	0.160894	59.00
60.00	06000	LABORATORY	36,978,234	28,786,948	65,765,182	0.134474	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,203,930	1,075,602	4,279,532	0.163383	62.00
64.00	06400	INTRAVENOUS THERAPY	1,138,784	119,347	1,258,131	0.581378	64.00
65.00	06500	RESPIRATORY THERAPY	10,132,456	1,969,535	12,101,991	0.245716	65.00
66.00	06600	PHYSICAL THERAPY	8,078,435	8,291,770	16,370,205	0.252769	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,166,288	2,918,703	8,084,991	0.222607	67.00
68.00	06800	SPEECH PATHOLOGY	1,373,070	446,696	1,819,766	0.299452	68.00
69.00	06900	ELECTROCARDIOLOGY	7,345,433	11,295,514	18,640,947	0.115497	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	371,414	570,610	942,024	0.333800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,023,538	8,488,331	22,511,869	0.658101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,439,797	13,703,910	29,143,707	0.370606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,656,504	46,404,319	111,060,823	0.192111	73.00
74.00	07400	RENAL DIALYSIS	3,202,942	621,056	3,823,998	0.288659	74.00
75.00	07500	ASC (NON-DISTINCT PART)	646,265	9,423,799	10,070,064	0.356124	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	248,989	248,989	0.590464	76.00
76.97	07697	CARDIAC REHABILITATION	21,417	993,900	1,015,317	0.903347	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	111,144	16,779,063	16,890,207	0.271584	90.00
91.00	09100	EMERGENCY	23,235,407	82,515,395	105,750,802	0.104998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,707,528	19,730,979	32,438,507	0.318048	92.00
93.00	04950	SLEEP LAB	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	432,998,520	448,845,817	881,844,337		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	432,998,520	448,845,817	881,844,337		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/29/2017 11:44 am
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ULTRASOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	SLEEP LAB	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF			112.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/29/2017 11:44 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,866,039	0	3,866,039	44,511	86.86	30.00
31.00	INTENSIVE CARE UNIT	681,602		681,602	5,742	118.70	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	92,908		92,908	2,275	40.84	43.00
44.00	SKILLED NURSING FACILITY	696,345		696,345	9,145	76.14	44.00
200.00	Total (lines 30-199)	5,336,894		5,336,894	61,673		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	13,024	1,131,265				
31.00	INTENSIVE CARE UNIT	2,138	253,781				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	4,322	329,077				
200.00	Total (lines 30-199)	19,484	1,714,123				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0250

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,119,965	103,585,972	0.010812	12,257,535	132,528	50.00
53.00	05300	ANESTHESIOLOGY	31,224	24,624,821	0.001268	2,224,680	2,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	983,459	122,765,451	0.008011	13,044,156	104,497	54.00
56.00	05600	RADIOISOTOPE	127,088	9,043,083	0.014054	971,151	13,649	56.00
56.01	05601	ULTRASOUND	18,043	13,950,815	0.001293	623,157	806	56.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	186,167	21,114,677	0.008817	3,924,559	34,603	59.00
60.00	06000	LABORATORY	432,749	65,765,182	0.006580	12,404,904	81,624	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,768	4,279,532	0.010928	931,191	10,176	62.00
64.00	06400	INTRAVENOUS THERAPY	17,401	1,258,131	0.013831	348,029	4,814	64.00
65.00	06500	RESPIRATORY THERAPY	155,261	12,101,991	0.012829	3,800,516	48,757	65.00
66.00	06600	PHYSICAL THERAPY	243,278	16,370,205	0.014861	2,049,685	30,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,823	8,084,991	0.005791	549,398	3,182	67.00
68.00	06800	SPEECH PATHOLOGY	14,902	1,819,766	0.008189	583,209	4,776	68.00
69.00	06900	ELECTROCARDIOLOGY	62,863	18,640,947	0.003372	2,820,515	9,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45,453	942,024	0.048250	174,214	8,406	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,095	22,511,869	0.005113	4,651,440	23,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	86,119	29,143,707	0.002955	5,407,741	15,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,747	111,060,823	0.003554	21,533,767	76,531	73.00
74.00	07400	RENAL DIALYSIS	73,785	3,823,998	0.019295	1,650,812	31,852	74.00
75.00	07500	ASC (NON-DISTINCT PART)	339,167	10,070,064	0.033681	249,922	8,418	75.00
76.00	03560	PULMONARY FUNCTION TESTING	13,358	248,989	0.053649	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	122,641	1,015,317	0.120791	7,367	890	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	346,391	16,890,207	0.020508	39,634	813	90.00
91.00	09100	EMERGENCY	813,585	105,750,802	0.007693	9,007,962	69,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	845,984	32,438,507	0.026080	4,379,700	114,223	92.00
93.00	04950	SLEEP LAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	6,682,316	757,301,871		103,635,244	832,398	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part III Date/Time Prepared: 5/29/2017 11:44 am
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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		0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0		0 31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0		0 32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0		0 33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0		0 34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0		0 41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0		0 42.00	
43.00	04300	NURSERY	0	0	0	0	0		0 43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0		0 44.00	
200.00		Total (lines 30-199)	0	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	44,511	0.00	13,024	0			0 30.00	
31.00	03100	INTENSIVE CARE UNIT	5,742	0.00	2,138	0			0 31.00	
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0			0 32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0			0 33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0			0 34.00	
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0			0 41.00	
42.00	04200	SUBPROVIDER	0	0.00	0	0			0 42.00	
43.00	04300	NURSERY	2,275	0.00	0	0			0 43.00	
44.00	04400	SKILLED NURSING FACILITY	9,145	0.00	4,322	0			0 44.00	
200.00		Total (lines 30-199)	61,673		19,484	0			0 200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0250

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0	93.00
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: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/29/2017 11:44 am
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Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	103,585,972	0.000000	0.000000	12,257,535	50.00
53.00	05300	ANESTHESIOLOGY	0	24,624,821	0.000000	0.000000	2,224,680	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,765,451	0.000000	0.000000	13,044,156	54.00
56.00	05600	RADIOISOTOPE	0	9,043,083	0.000000	0.000000	971,151	56.00
56.01	05601	ULTRASOUND	0	13,950,815	0.000000	0.000000	623,157	56.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,114,677	0.000000	0.000000	3,924,559	59.00
60.00	06000	LABORATORY	0	65,765,182	0.000000	0.000000	12,404,904	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,279,532	0.000000	0.000000	931,191	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,258,131	0.000000	0.000000	348,029	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,101,991	0.000000	0.000000	3,800,516	65.00
66.00	06600	PHYSICAL THERAPY	0	16,370,205	0.000000	0.000000	2,049,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,084,991	0.000000	0.000000	549,398	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,819,766	0.000000	0.000000	583,209	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,640,947	0.000000	0.000000	2,820,515	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	942,024	0.000000	0.000000	174,214	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,511,869	0.000000	0.000000	4,651,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	29,143,707	0.000000	0.000000	5,407,741	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	111,060,823	0.000000	0.000000	21,533,767	73.00
74.00	07400	RENAL DIALYSIS	0	3,823,998	0.000000	0.000000	1,650,812	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	10,070,064	0.000000	0.000000	249,922	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	248,989	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,015,317	0.000000	0.000000	7,367	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	16,890,207	0.000000	0.000000	39,634	90.00
91.00	09100	EMERGENCY	0	105,750,802	0.000000	0.000000	9,007,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	32,438,507	0.000000	0.000000	4,379,700	92.00
93.00	04950	SLEEP LAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	757,301,871			103,635,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/29/2017 11:44 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	11,356,409	0	50.00
53.00	05300 ANESTHESIOLOGY	0	2,961,967	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,174,504	0	54.00
56.00	05600 RADIOISOTOPE	0	1,729,373	0	56.00
56.01	05601 ULTRASOUND	0	1,196,701	0	56.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,135,801	0	59.00
60.00	06000 LABORATORY	0	4,449,494	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	238,830	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	29,349	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	509,464	0	65.00
66.00	06600 PHYSICAL THERAPY	0	83,931	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	43,760	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	30,992	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,722,130	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	108,657	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,032,995	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,855,906	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,628,869	0	73.00
74.00	07400 RENAL DIALYSIS	0	246,077	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	1,794,627	0	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	105,066	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	283,923	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	4,851,260	0	90.00
91.00	09100 EMERGENCY	0	11,245,481	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,318,220	0	92.00
93.00	04950 SLEEP LAB	0	0	0	93.00
200.00	Total (lines 50-199)	0	83,133,786	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.122624	11,356,409	0	556	1,392,568	50.00
53.00	05300	ANESTHESIOLOGY	0.021876	2,961,967	0	0	64,796	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082642	17,174,504	0	0	1,419,335	54.00
56.00	05600	RADIOISOTOPE	0.189481	1,729,373	0	0	327,683	56.00
56.01	05601	ULTRASOUND	0.081638	1,196,701	0	0	97,696	56.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160894	3,135,801	0	0	504,532	59.00
60.00	06000	LABORATORY	0.134474	4,449,494	0	1,600	598,341	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.163383	238,830	0	0	39,021	62.00
64.00	06400	INTRAVENOUS THERAPY	0.581378	29,349	0	0	17,063	64.00
65.00	06500	RESPIRATORY THERAPY	0.245716	509,464	0	0	125,183	65.00
66.00	06600	PHYSICAL THERAPY	0.252769	83,931	0	0	21,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.222607	43,760	0	0	9,741	67.00
68.00	06800	SPEECH PATHOLOGY	0.299452	30,992	0	0	9,281	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115497	2,722,130	0	0	314,398	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333800	108,657	0	0	36,270	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.658101	2,032,995	0	3,036	1,337,916	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.370606	2,855,906	0	191,767	1,058,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192111	9,628,869	0	68,646	1,849,812	73.00
74.00	07400	RENAL DIALYSIS	0.288659	246,077	0	0	71,032	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.356124	1,794,627	0	0	639,110	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.590464	105,066	0	0	62,038	76.00
76.97	07697	CARDIAC REHABILITATION	0.903347	283,923	0	0	256,481	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.271584	4,851,260	0	0	1,317,525	90.00
91.00	09100	EMERGENCY	0.104998	11,245,481	0	94	1,180,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318048	4,318,220	0	0	1,373,401	92.00
93.00	04950	SLEEP LAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		83,133,786	0	265,699	14,123,607	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (Line 200 +/- Line 201)		83,133,786	0	265,699	14,123,607	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/29/2017 11:44 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	68		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
56.01 05601 ULTRASOUND	0	0		56.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	215		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,998		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	71,070		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13,188		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	10		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04950 SLEEP LAB	0	0		93.00
200.00 Subtotal (see instructions)	0	86,549		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	0	86,549		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0250
Component CCN: 14-5599

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2017 11:44 am

Title XVIII

Skilled Nursing Facility

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/29/2017 11:44 am
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	Title XVIII	Skilled Nursing Facility	PPS
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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	103,585,972	0.000000	0.000000	3,167	50.00
53.00 05300 ANESTHESIOLOGY	0	24,624,821	0.000000	0.000000	2,224	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	122,765,451	0.000000	0.000000	89,164	54.00
56.00 05600 RADIOISOTOPE	0	9,043,083	0.000000	0.000000	22,923	56.00
56.01 05601 ULTRASOUND	0	13,950,815	0.000000	0.000000	7,467	56.01
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	21,114,677	0.000000	0.000000	1,660	59.00
60.00 06000 LABORATORY	0	65,765,182	0.000000	0.000000	510,982	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,279,532	0.000000	0.000000	17,291	62.00
64.00 06400 INTRAVENOUS THERAPY	0	1,258,131	0.000000	0.000000	4,009	64.00
65.00 06500 RESPIRATORY THERAPY	0	12,101,991	0.000000	0.000000	234,473	65.00
66.00 06600 PHYSICAL THERAPY	0	16,370,205	0.000000	0.000000	1,537,134	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	8,084,991	0.000000	0.000000	1,841,003	67.00
68.00 06800 SPEECH PATHOLOGY	0	1,819,766	0.000000	0.000000	96,097	68.00
69.00 06900 ELECTROCARDIOLOGY	0	18,640,947	0.000000	0.000000	16,091	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	942,024	0.000000	0.000000	1,228	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,511,869	0.000000	0.000000	352,752	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	29,143,707	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	111,060,823	0.000000	0.000000	709,584	73.00
74.00 07400 RENAL DIALYSIS	0	3,823,998	0.000000	0.000000	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	10,070,064	0.000000	0.000000	1,148	75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	248,989	0.000000	0.000000	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	1,015,317	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	16,890,207	0.000000	0.000000	7,637	90.00
91.00 09100 EMERGENCY	0	105,750,802	0.000000	0.000000	6,852	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	32,438,507	0.000000	0.000000	0	92.00
93.00 04950 SLEEP LAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (Lines 50-199)			5,462,886	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/29/2017 11:44 am
Title XVIII		Skilled Nursing Facility	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
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
56.01	05601 ULTRASOUND	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04950 SLEEP LAB	0	0	0	93.00
200.00	Total (Lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/29/2017 11:44 am
		Title XIX	Hospital	Cost

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	0.122624	0	0	876,476	0 50.00
53.00 05300 ANESTHESIOLOGY	0.021876	0	0	218,084	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.082642	0	0	3,052,973	0 54.00
56.00 05600 RADIOISOTOPE	0.189481	0	0	123,644	0 56.00
56.01 05601 ULTRASOUND	0.081638	0	0	907,775	0 56.01
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.160894	0	0	119,682	0 59.00
60.00 06000 LABORATORY	0.134474	0	0	1,449,712	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.163383	0	0	47,929	0 62.00
64.00 06400 INTRAVENOUS THERAPY	0.581378	0	0	3,409	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.245716	0	0	69,274	0 65.00
66.00 06600 PHYSICAL THERAPY	0.252769	0	0	142,481	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.222607	0	0	77,862	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.299452	0	0	8,004	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.115497	0	0	315,262	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.333800	0	0	20,955	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.658101	0	0	143,505	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.370606	0	0	30,751	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.192111	0	0	1,577,843	0 73.00
74.00 07400 RENAL DIALYSIS	0.288659	0	0	4,670	0 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.356124	0	0	127,634	0 75.00
76.00 03560 PULMONARY FUNCTION TESTING	0.590464	0	0	75	0 76.00
76.97 07697 CARDIAC REHABILITATION	0.903347	0	0	13,677	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	0.271584	0	0	353,603	0 90.00
91.00 09100 EMERGENCY	0.104998	0	0	6,610,080	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.318048	0	0	807,135	0 92.00
93.00 04950 SLEEP LAB	0.000000	0	0	0	0 93.00
200.00	Subtotal (see instructions)	0	0	17,102,495	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	17,102,495	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0250

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

Worksheet D
Part V
Date/Time Prepared:
5/29/2017 11:44 am

		Title XIX		Hospital	Cost
Cost Center Description	Costs		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	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	107,477	50.00
53.00	05300	ANESTHESIOLOGY	0	4,771	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,304	54.00
56.00	05600	RADIOISOTOPE	0	23,428	56.00
56.01	05601	ULTRASOUND	0	74,109	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,256	59.00
60.00	06000	LABORATORY	0	194,949	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,831	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,982	64.00
65.00	06500	RESPIRATORY THERAPY	0	17,022	65.00
66.00	06600	PHYSICAL THERAPY	0	36,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,333	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,397	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,412	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,995	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	94,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	303,121	73.00
74.00	07400	RENAL DIALYSIS	0	1,348	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	45,454	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	44	76.00
76.97	07697	CARDIAC REHABILITATION	0	12,355	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	96,033	90.00
91.00	09100	EMERGENCY	0	694,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	256,708	92.00
93.00	04950	SLEEP LAB	0	0	93.00
200.00		Subtotal (see instructions)	0	2,317,227	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (Line 200 +/- Line 201)	0	2,317,227	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/29/2017 11:44 am
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)		44,511	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		44,511	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)		34,771	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)		13,024	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)		47,147,641	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)		47,147,641	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)		47,147,641	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,059.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,795,542	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)		13,795,542	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/29/2017 11:44 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	10,365,421	5,742	1,805.19	2,138	3,859,496	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				19,775,321		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				37,430,359		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,385,046		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				832,398		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				2,217,444		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				35,212,915		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)				9,740		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,059.24		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				10,316,998		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,866,039	47,147,641	0.081999	10,316,998	845,984	90.00
91.00	Nursing School cost	0	47,147,641	0.000000	10,316,998	0	91.00
92.00	Allied health cost	0	47,147,641	0.000000	10,316,998	0	92.00
93.00	All other Medical Education	0	47,147,641	0.000000	10,316,998	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Skilled Nursing Facility	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)		9,145	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,145	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)		9,145	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,322	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)		6,614,072	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)		6,614,072	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)		6,614,072	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250 Component CCN: 14-5599		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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 (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					6,614,072	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					723.24	71.00
72.00	Program routine service cost (line 9 x line 71)					3,125,843	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					3,125,843	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					3,125,843	83.00
84.00	Program inpatient ancillary services (see instructions)					1,345,581	84.00
85.00	Utilization review - physician compensation (see instructions)					30,000	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					4,501,424	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: 14-0250 Component CCN: 14-5599		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/29/2017 11:44 am	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V																																																																																																											
	1.00	2.00	3.00	4.00	5.00																																																																																																											
PART I - NOT IN APPROVED TEACHING PROGRAM																																																																																																																
Hospital Inpatient Routine Services:																																																																																																																
1.00 Total cost of services rendered	0.00	0			1.00																																																																																																											
2.00 ADULTS & PEDIATRICS	0.00	0	44,511	0.00	2.00																																																																																																											
3.00 INTENSIVE CARE UNIT	0.00	0	5,742	0.00	3.00																																																																																																											
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5.00 BURN INTENSIVE CARE UNIT	0.00	0	0	0.00	5.00																																																																																																											
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7.00 OTHER SPECIAL CARE (SPECIFY)					7.00																																																																																																											
8.00 NURSERY	0.00	0	2,275	0.00	8.00																																																																																																											
9.00 Subtotal (sum of lines 2 through 8)	0.00	0			9.00																																																																																																											
10.00 SUBPROVIDER - IPF					10.00																																																																																																											
11.00 SUBPROVIDER - IRF	0.00	0	0	0.00	11.00																																																																																																											
12.00 SUBPROVIDER	0.00	0	0	0.00	12.00																																																																																																											
13.00 SKILLED NURSING FACILITY	0.00	0	9,145	0.00	13.00																																																																																																											
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Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)																																																																																																											
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42.00 Total (sum of lines 37 through 41)	0		0		42.00																																																																																																											

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-0250

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

Worksheet D-2

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, -)	
	1.00	2.00	3.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF	col. 9, line 11.00		0 col. 9, line 39.00	47.00
48.00 SUBPROVIDER	col. 9, line 12.00		0 col. 9, line 40.00	48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered					1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	13,024	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	2,138	0	0	0	3.00
4.00	CORONARY CARE UNIT	0	0	0	0	4.00
5.00	BURN INTENSIVE CARE UNIT	0	0	0	0	5.00
6.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	6.00
7.00	OTHER SPECIAL CARE (SPECIFY)					7.00
8.00	NURSERY		0	0	0	8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	9.00
10.00	SUBPROVIDER - IPF			0	0	10.00
11.00	SUBPROVIDER - IRF	0	0	0	0	11.00
12.00	SUBPROVIDER	0	0	0	0	12.00
13.00	SKILLED NURSING FACILITY	4,322	0	0	0	13.00
14.00	NURSING FACILITY					14.00
15.00	OTHER LONG TERM CARE					15.00
16.00	HOME HEALTH AGENCY					16.00
17.00	CMHC					17.00
17.10	CORF					17.10
18.00	AMBULATORY SURGICAL CENTER (D.P.)					18.00
19.00	HOSPICE					19.00
20.00	Subtotal (sum of lines 9 through 19)					20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC	0	0	0	0	21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	22.00
23.00	CLINIC	4,890,894	355,070	0	0	23.00
24.00	EMERGENCY	20,253,537	7,576,130	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)	8,697,920	1,268,761	0	0	25.00
26.00	SLEEP LAB	0	0	0	0	26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	27.00
28.00	Total (sum of lines 20 and 27)					28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT	0	0	0		33.00
34.00	BURN INTENSIVE CARE UNIT	0	0	0		34.00
35.00	SURGICAL INTENSIVE CARE UNIT	0	0	0		35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF	0	0	0		39.00
40.00	SUBPROVIDER	0	0	0		40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-0250

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

Worksheet D-2

Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF	0	line 22	0	47.00
48.00	SUBPROVIDER	0	line 22	0	48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		28,243,944	30.00
31.00	03100	INTENSIVE CARE UNIT		9,671,439	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.122624	12,257,535	1,503,068 50.00
53.00	05300	ANESTHESIOLOGY	0.021876	2,224,680	48,667 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082642	13,044,156	1,077,995 54.00
56.00	05600	RADIOISOTOPE	0.189481	971,151	184,015 56.00
56.01	05601	ULTRASOUND	0.081638	623,157	50,873 56.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160894	3,924,559	631,438 59.00
60.00	06000	LABORATORY	0.134474	12,404,904	1,668,137 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.163383	931,191	152,141 62.00
64.00	06400	INTRAVENOUS THERAPY	0.581378	348,029	202,336 64.00
65.00	06500	RESPIRATORY THERAPY	0.245716	3,800,516	933,848 65.00
66.00	06600	PHYSICAL THERAPY	0.252769	2,049,685	518,097 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.222607	549,398	122,300 67.00
68.00	06800	SPEECH PATHOLOGY	0.299452	583,209	174,643 68.00
69.00	06900	ELECTROCARDIOLOGY	0.115497	2,820,515	325,761 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333800	174,214	58,153 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.658101	4,651,440	3,061,117 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.370606	5,407,741	2,004,141 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192111	21,533,767	4,136,874 73.00
74.00	07400	RENAL DIALYSIS	0.288659	1,650,812	476,522 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.356124	249,922	89,003 75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.590464	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.903347	7,367	6,655 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.271584	39,634	10,764 90.00
91.00	09100	EMERGENCY	0.104998	9,007,962	945,818 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318048	4,379,700	1,392,955 92.00
93.00	04950	SLEEP LAB	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		103,635,244	19,775,321 200.00
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)		103,635,244	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/29/2017 11:44 am	
		Title XVIII	Skilled Nursing Facility	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
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.122624	3,167	388 50.00
53.00	05300	ANESTHESIOLOGY	0.021876	2,224	49 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082642	89,164	7,369 54.00
56.00	05600	RADIOISOTOPE	0.189481	22,923	4,343 56.00
56.01	05601	ULTRASOUND	0.081638	7,467	610 56.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160894	1,660	267 59.00
60.00	06000	LABORATORY	0.134474	510,982	68,714 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.163383	17,291	2,825 62.00
64.00	06400	INTRAVENOUS THERAPY	0.581378	4,009	2,331 64.00
65.00	06500	RESPIRATORY THERAPY	0.245716	234,473	57,614 65.00
66.00	06600	PHYSICAL THERAPY	0.252769	1,537,134	388,540 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.222607	1,841,003	409,820 67.00
68.00	06800	SPEECH PATHOLOGY	0.299452	96,097	28,776 68.00
69.00	06900	ELECTROCARDIOLOGY	0.115497	16,091	1,858 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333800	1,228	410 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.658101	352,752	232,146 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.370606	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192111	709,584	136,319 73.00
74.00	07400	RENAL DIALYSIS	0.288659	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.356124	1,148	409 75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.590464	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.903347	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.271584	7,637	2,074 90.00
91.00	09100	EMERGENCY	0.104998	6,852	719 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318048	0	0 92.00
93.00	04950	SLEEP LAB	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		5,462,886	1,345,581 200.00
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)		5,462,886	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/29/2017 11:44 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,750,975	30.00
31.00	03100	INTENSIVE CARE UNIT		1,066,202	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		834,872	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.122624	981,340	50.00
53.00	05300	ANESTHESIOLOGY	0.021876	344,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082642	1,401,089	54.00
56.00	05600	RADIOISOTOPE	0.189481	93,316	56.00
56.01	05601	ULTRASOUND	0.081638	101,590	56.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160894	277,285	59.00
60.00	06000	LABORATORY	0.134474	1,806,499	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.163383	122,467	62.00
64.00	06400	INTRAVENOUS THERAPY	0.581378	54,824	64.00
65.00	06500	RESPIRATORY THERAPY	0.245716	425,052	65.00
66.00	06600	PHYSICAL THERAPY	0.252769	110,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.222607	39,764	67.00
68.00	06800	SPEECH PATHOLOGY	0.299452	25,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115497	262,944	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.333800	7,807	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.658101	408,665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.370606	152,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192111	2,512,412	73.00
74.00	07400	RENAL DIALYSIS	0.288659	49,596	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.356124	14,803	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.590464	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.903347	843	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.271584	1,467	90.00
91.00	09100	EMERGENCY	0.104998	966,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.318048	461,626	92.00
93.00	04950	SLEEP LAB	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		10,622,214	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		10,622,214	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		21,789,835	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,831,558	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)		452,208	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)		213.21	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)		4.05	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.33	31.00
32.00	Sum of lines 30 and 31		27.38	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.80	33.00
34.00	Disproportionate share adjustment (see instructions)		873,831	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000		0.000000000 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,531,132		1,428,723 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,146,257		360,117 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,506,374		
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	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		32,453,806	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		32,453,806	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,536,293	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)		34,990,099	59.00
60.00	Primary payer payments		2,749	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		34,987,350	61.00
62.00	Deductibles billed to program beneficiaries		2,867,564	62.00
63.00	Coinurance billed to program beneficiaries		131,047	63.00
64.00	Allowable bad debts (see instructions)		894,362	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		581,335	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		508,350	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,570,074	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 PER PS&R		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)		-10,001	70.93
70.94	HRR adjustment amount (see instructions)		-60,639	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/29/2017 11:44 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			32,499,434	71.00
71.01	Sequestration adjustment (see instructions)			649,989	71.01
72.00	Interim payments			31,723,466	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)			125,979	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			457,144	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		86,549	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		14,123,607	2.00
3.00	PPS payments		13,189,258	3.00
4.00	Outlier payment (see instructions)		26,656	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.778	5.00
6.00	Line 2 times line 5		10,988,166	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)		86,549	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		265,699	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)		265,699	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)		265,699	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		179,150	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)		86,549	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)		13,215,914	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		38,353	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,621,958	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		10,642,152	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		10,642,152	30.00
31.00	Primary payer payments		347	31.00
32.00	Subtotal (line 30 minus line 31)		10,641,805	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)		798,754	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		519,190	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		463,244	36.00
37.00	Subtotal (see instructions)		11,160,995	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)		11,160,995	40.00
40.01	Sequestration adjustment (see instructions)		223,220	40.01
41.00	Interim payments		10,918,426	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		19,349	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: 14-0250 Component CCN: 14-5599	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Skilled Nursing Facility	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)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		0	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)			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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		0	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0250

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2017 11:44 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		31,663,557		10,826,661	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/18/2016	193,646	08/18/2016	91,765	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	12/20/2016	133,737		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)		59,909		91,765	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)		31,723,466		10,918,426	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		125,979		19,349	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		31,849,445		10,937,775	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: 14-0250
Component CCN: 14-5599

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2017 11:44 am

Title XVIII

Skilled Nursing
Facility

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		1,935,419		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,935,419		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		35,059		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,970,478		0	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: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		9,835	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		15,162	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		8,218	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		40,513	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		881,844,337	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		8,692,860	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,080,856	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,080,856	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		105,938	7.00
8.00	Allowable bad debts (see instructions)		8,883	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		5,774	10.00
11.00	Utilization review		30,000	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		2,010,692	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		2,010,692	15.00
15.01	Sequestration adjustment (see instructions)		40,214	15.01
16.00	Interim payments		1,935,419	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		35,059	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0250

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

Worksheet G

Date/Time Prepared:
5/29/2017 11:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	72,316,000	0	0	0	1.00
2.00	Temporary investments	71,537,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	544,684,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	224,106,000	0	0	0	9.00
10.00	Due from other funds	25,422,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	938,065,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	148,150,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,838,618,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,441,911,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,348,043,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,080,636,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,363,740,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	379,088,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,742,828,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,761,529,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	325,076,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	370,195,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	57,524,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	421,041,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,173,836,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,517,328,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	897,259,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,414,587,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,588,423,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,173,106,000	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,173,106,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,761,529,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0250

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

Worksheet G-1

Date/Time Prepared:
5/29/2017 11:44 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		3,678,454,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,553,561			2.00
3.00	Total (sum of line 1 and line 2)		3,687,007,561		0	3.00
4.00	SYSTEM ADJUSTMENT	486,098,439		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)		486,098,439		0	10.00
11.00	Subtotal (line 3 plus line 10)		4,173,106,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,173,106,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	SYSTEM ADJUSTMENT		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	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0250

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2017 11:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	91,273,262		91,273,262	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	8,911,680		8,911,680	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)	100,184,942		100,184,942	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	26,284,384		26,284,384	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	26,284,384		26,284,384	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	126,469,326		126,469,326	17.00
18.00	Ancillary services	272,308,440	320,605,776	592,914,216	18.00
19.00	Outpatient services	36,737,917	128,449,236	165,187,153	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON RE - ACCRUAL	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	435,515,683	449,055,012	884,570,695	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		212,354,339		29.00
30.00		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)		212,354,339		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0250

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

Worksheet G-3

Date/Time Prepared:
5/29/2017 11:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	884,570,695	1.00
2.00	Less contractual allowances and discounts on patients' accounts	665,655,334	2.00
3.00	Net patient revenues (line 1 minus line 2)	218,915,361	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	212,354,339	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,561,022	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	25,548	6.00
7.00	Income from investments	0	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	512,124	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.)	6,830	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	494,941	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	953,096	24.00
25.00	Total other income (sum of lines 6-24)	1,992,539	25.00
26.00	Total (line 5 plus line 25)	8,553,561	26.00
27.00	CORPORATE EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,553,561	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet I-5 Date/Time Prepared: 5/29/2017 11:44 am
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		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0250	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/29/2017 11:44 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,381,683	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		18,854	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)		111.65	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)		4.05	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.33	8.00
9.00	Sum of lines 7 and 8		27.38	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.70	10.00
11.00	Disproportionate share adjustment (see instructions)		135,756	11.00
12.00	Total prospective capital payments (see instructions)		2,536,293	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