

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: 14-0292	Period: From 01/01/2016 To 12/31/2016	worksheet 5 Parts I-III Date/Time Prepared: 5/24/2017 9:22 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 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
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/24/2017 Time: 9:22 am

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 ADVENTIST GLENOAKS HOSPITAL (14-0292) 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.

Encryption Information

ECR: Date: 5/24/2017 Time: 9:22 am
 X.k1uBI.ss3JWwyOFTNJqgd4NJFI0
 BbSaE0nGwZd12Vnm581x31z1AwgTD7
 Yi.21jpwvG0FeBwn
 PI: Date: 5/24/2017 Time: 9:22 am
 28R48HHvNF2kevOBIE:kvbH1C25VS0
 6xBpn0eXw:Exmz0kTCmdk:UuYQMfK5
 u46L07NGxe02.i1p

(Signed) 
 Officer or Administrator of Provider(s)
 VP/CFO
 Title
 05/25/2017
 Date

	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	84,318	-35,278	0	0	1.00
2.00 Subprovider - IPF	0	21,929	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	106,247	-35,278	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: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:20 am
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 701 WINTHROP AVENUE	PO Box:		Zip Code: 60139-		County: DUPAGE			1.00	
2.00	City: GLENDALE HEIGHTS	State: IL							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ADVENTIST GLENOAKS HOSPITAL	140292	16974	1	11/23/1982	N	P	O	3.00
4.00	Subprovider - IPF	GLEN OAKS MED CTR PSYCH UNIT	14S292	16974	4	01/01/1984	N	P	T	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016		20.00
21.00	Type of Control (see instructions)						1			21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,487	1,208	0	40	6,420	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 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.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:20 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)	N			37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	Y	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.06		0.00	0.00			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)						
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10				0.00	0.00	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.						
61.20				0.00	0.00	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.						
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00					0.00	62.00
Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						
62.01					0.00	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)						
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00					N	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)						
			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 Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00			0.00	0.00	0.000000	64.00
Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						
		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				0.00	0.00	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)						

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00			95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00			97.00
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete wkst. D-2, Pt. II.						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	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	355,636	0				118.01
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00

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		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	HF8013				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: ADVENTIST HEALTH SYSTEM	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001			141.00
142.00	Street: 900 HOPE WAY	PO Box:					142.00
143.00	City: ALTAMONTE SPRINGS	State: FL		Zip Code: 32714			143.00
						1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y				144.00
						1.00	
145.00	If costs for renal services are claimed on wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N		165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:20 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2015	09/30/2016	170.00
			1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0292		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 9:20 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.	N					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.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2016	Y	04/01/2016		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MIKE		THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTIST HEALTH SYSTEM SUNBELT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	407-357-2338		MIKE.THOMPSON3@AHSS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0292

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

Worksheet S-2
Part II
Date/Time Prepared:
5/24/2017 9:20 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.	REIMBURSEMENT MANAGER	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

		1.00
Cost Report Preparer Contact Information		
1.00	First Name	1.00
2.00	Last Name	2.00
3.00	Title	3.00
4.00	Employer	4.00
5.00	Phone Number	5.00
6.00	E-mail Address	6.00
7.00	Department	7.00
8.00	Mailing Address 1	8.00
9.00	Mailing Address 2	9.00
10.00	City	10.00
11.00	State	11.00
12.00	Zip	12.00
Officer or Administrator of Provider Contact Information		
13.00	First Name	13.00
14.00	Last Name	14.00
15.00	Title	15.00
16.00	Employer	16.00
17.00	Phone Number	17.00
18.00	E-mail Address	18.00
19.00	Department	19.00
20.00	Mailing Address 1	20.00
21.00	Mailing Address 2	21.00
22.00	City	22.00
23.00	State	23.00
24.00	Zip	24.00

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use w/s D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2017 9:20 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	117	42,822	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)		117	42,822	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		127	46,482	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,856		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		143			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,388	2,153	22,013			1.00
2.00 HMO and other (see instructions)	601	7,668				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)	6,388	2,153	22,013			7.00
8.00 INTENSIVE CARE UNIT	965	122	2,320			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		190	638			13.00
14.00 Total (see instructions)	7,353	2,465	24,971	0.00	460.85	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,770	57	4,479	0.00	23.94	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	55			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	484.79	27.00
28.00 Observation Bed Days		91	1,922			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	22	69			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

Component	Full Time Equivalents		Discharges			Total All Patients	
	Nonpaid Workers		Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,335	582	5,078	1.00	
2.00 HMO and other (see instructions)			143	1,520		2.00	
3.00 HMO IPF Subprovider				35		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	1,335	582	5,078	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF	0.00	0	234	7	414	16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25	
27.00 Total (sum of lines 14-26)	0.00					27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	34,951,991	2,243,398	37,195,389	1,014,441.00	36.67
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		266,312	0	266,312	3,460.00	76.97
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		220,653	0	220,653	4,166.00	52.97
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,448,472	-377,128	6,071,344	188,451.00	32.22
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		745,704	0	745,704	16,844.00	44.27
12.00	Contract labor: Top level management and other management and administrative services		264,431	0	264,431	2,082.00	127.01
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		2,676,447	0	2,676,447	50,532.00	52.97
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	wage-related costs (core) (see instructions)		6,785,337	0	6,785,337		
18.00	wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,558,856	0	1,558,856		
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		41,869	0	41,869		
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		569,458	0	569,458		
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	61,491	0	61,491	2,083.00	29.52
27.00	Administrative & General	5.00	3,202,716	2,147,109	5,349,825	97,781.00	54.71

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0292

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2017 9:20 am

		Worksheet A Line Number	Amount Reported	Reclassificati 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.)		32,982	0	32,982	190.00	173.59	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	929,055	0	929,055	37,191.00	24.98	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,124	0	2,124	1,303.00	1.63	32.00
33.00	Housekeeping under contract (see instructions)		1,129,478	0	1,129,478	55,574.00	20.32	33.00
34.00	Dietary	10.00	268	-169	99	355.00	0.28	34.00
35.00	Dietary under contract (see instructions)		1,497,668	0	1,497,668	59,060.00	25.36	35.00
36.00	Cafeteria	11.00	0	169	169	608.00	0.28	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	961,102	0	961,102	22,551.00	42.62	38.00
39.00	Central Services and Supply	14.00	266,958	25,895	292,853	15,506.00	18.89	39.00
40.00	Pharmacy	15.00	1,560,782	0	1,560,782	33,759.00	46.23	40.00
41.00	Medical Records & Medical Records Library	16.00	263,548	59,394	322,942	15,010.00	21.52	41.00
42.00	Social Service	17.00	607,930	0	607,930	14,828.00	41.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0292

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2017 9:20 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	37,125,154	2,243,398	39,368,552	1,121,639.00	35.10	1.00
2.00	Excluded area salaries (see instructions)	6,448,472	-377,128	6,071,344	188,451.00	32.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,676,682	2,620,526	33,297,208	933,188.00	35.68	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,686,582	0	3,686,582	69,458.00	53.08	4.00
5.00	Subtotal wage-related costs (see inst.)	7,354,795	0	7,354,795	0.00	22.09	5.00
6.00	Total (sum of lines 3 thru 5)	41,718,059	2,620,526	44,338,585	1,002,646.00	44.22	6.00
7.00	Total overhead cost (see instructions)	10,516,102	2,232,398	12,748,500	355,799.00	35.83	7.00

Provider CCN: 14-0292

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,414,798	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	3,753,862	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	25,537	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'workers' Compensation Insurance	311,046	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,718,522	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	41,655	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	120,641	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,386,061	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0292

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

Worksheet S-3
Part V
Date/Time Prepared:
5/24/2017 9:20 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	745,704	0	1.00
2.00	Hospital	745,704	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

				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)			0.306636	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			28,202,017	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			82,684,816	6.00
7.00	Medicaid cost (line 1 times line 6)			25,354,141	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)			0	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)			1,078,599	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			330,737	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)			330,737	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			24,021	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			330,737	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	5,621,218	1,096,857	6,718,075	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,723,668	336,336	2,060,004	21.00
22.00	Partial payment by patients approved for charity care	6,227	0	6,227	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,717,441	336,336	2,053,777	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			3,329,955	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			359,691	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,970,264	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			910,790	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,964,567	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,295,304	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0292

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

Worksheet A

Date/Time Prepared:
5/24/2017 9:20 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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	2,127,990	2,127,990	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,569,760	2,569,760	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	61,491	5,137,683	5,199,174	-120	5,199,054	4.00
5.01	01160	COMMUNICATIONS	0	164,290	164,290	-1,137	163,153	5.01
5.04	00570	ADMITTING	784,414	119,907	904,321	-120	904,201	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	2,418,302	19,566,234	21,984,536	-391,900	21,592,636	5.06
7.00	00700	OPERATION OF PLANT	929,055	1,935,833	2,864,888	-555	2,864,333	7.00
9.00	00900	HOUSEKEEPING	2,124	1,535,595	1,537,719	-1,530	1,536,189	9.00
10.00	01000	DIETARY	268	2,125,275	2,125,543	-1,341,665	783,878	10.00
11.00	01100	CAFETERIA	0	0	0	1,341,665	1,341,665	11.00
13.00	01300	NURSING ADMINISTRATION	961,102	210,976	1,172,078	-595	1,171,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	266,958	221,920	488,878	134,429	623,307	14.00
15.00	01500	PHARMACY	1,560,782	2,665,876	4,226,658	-2,498,278	1,728,380	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	263,548	90,492	354,040	65,538	419,578	16.00
17.00	01700	SOCIAL SERVICE	607,930	228,025	835,955	-120	835,835	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,880,415	1,974,678	11,855,093	-1,091,386	10,763,707	30.00
31.00	03100	INTENSIVE CARE UNIT	1,762,704	709,459	2,472,163	-75	2,472,088	31.00
40.00	04000	SUBPROVIDER - IPF	2,112,027	185,408	2,297,435	-340,692	1,956,743	40.00
43.00	04300	NURSERY	0	7,415	7,415	483,441	490,856	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,327,421	766,017	2,093,438	-4,949	2,088,489	50.00
51.00	05100	RECOVERY ROOM	271,882	20,817	292,699	0	292,699	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71	0	71	928,983	929,054	52.00
53.00	05300	ANESTHESIOLOGY	48,367	35,666	84,033	-120	83,913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	916,684	313,735	1,230,419	-204	1,230,215	54.00
56.00	05600	RADIOISOTOPE	146,833	134,997	281,830	-108,591	173,239	56.00
57.00	05700	CT SCAN	403,222	93,991	497,213	0	497,213	57.00
58.00	05800	MRI	167,524	23,782	191,306	-120	191,186	58.00
59.00	05900	CARDIAC CATHETERIZATION	641,449	485,091	1,126,540	-2,640	1,123,900	59.00
60.00	06000	LABORATORY	1,332,893	1,108,196	2,441,089	-90,629	2,350,460	60.00
65.00	06500	RESPIRATORY THERAPY	688,138	189,519	877,657	-11,962	865,695	65.00
66.00	06600	PHYSICAL THERAPY	0	1,018,031	1,018,031	-128,053	889,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	48,840	48,840	0	48,840	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,940	19,940	0	19,940	68.00
69.00	06900	ELECTROCARDIOLOGY	337,068	164,741	501,809	-720	501,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,292	825	16,117	0	16,117	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	757,204	757,204	103,854	861,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,951,820	1,951,820	11,110	1,962,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,533	20,533	2,269,557	2,290,090	73.00
74.00	07400	RENAL DIALYSIS	0	259,986	259,986	0	259,986	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	6,575	35,012	41,587	0	41,587	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	295,693	90,711	386,404	-27,638	358,766	90.00
91.00	09100	EMERGENCY	2,405,314	2,334,163	4,739,477	-220	4,739,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		3,742,807	3,742,807	-3,992,308	-249,501	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,615,546	50,495,490	81,111,036	0	81,111,036	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,076	26,303	83,379	0	83,379	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,008,564	2,008,564	0	2,008,564	192.00
192.03	19203	OP PHARMACY	151,581	373,249	524,830	0	524,830	192.03
194.00	07950	FOUNDATION	170,839	33,089	203,928	0	203,928	194.00
194.01	07951	MARKETING	0	206,713	206,713	0	206,713	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	3,956,949	1,394,893	5,351,842	0	5,351,842	194.03
200.00		TOTAL (SUM OF LINES 118-199)	34,951,991	54,538,301	89,490,292	0	89,490,292	200.00

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,369	2,183,359	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	226,731	2,796,491	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-95,273	5,103,781	4.00
5.01	01160	COMMUNICATIONS	-23,875	139,278	5.01
5.04	00570	ADMITTING	80	904,281	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	3,370,604	24,963,240	5.06
7.00	00700	OPERATION OF PLANT	-22,988	2,841,345	7.00
9.00	00900	HOUSEKEEPING	-5,225	1,530,964	9.00
10.00	01000	DIETARY	-348,918	434,960	10.00
11.00	01100	CAFETERIA	0	1,341,665	11.00
13.00	01300	NURSING ADMINISTRATION	-5,180	1,166,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	623,307	14.00
15.00	01500	PHARMACY	-13,987	1,714,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-138	419,440	16.00
17.00	01700	SOCIAL SERVICE	-1,938	833,897	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-510,661	10,253,046	30.00
31.00	03100	INTENSIVE CARE UNIT	-237,633	2,234,455	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,956,743	40.00
43.00	04300	NURSERY	0	490,856	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-4,405	2,084,084	50.00
51.00	05100	RECOVERY ROOM	0	292,699	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	929,054	52.00
53.00	05300	ANESTHESIOLOGY	-132	83,781	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-80,869	1,149,346	54.00
56.00	05600	RADIOISOTOPE	0	173,239	56.00
57.00	05700	CT SCAN	0	497,213	57.00
58.00	05800	MRI	0	191,186	58.00
59.00	05900	CARDIAC CATHETERIZATION	-104,569	1,019,331	59.00
60.00	06000	LABORATORY	-1,732	2,348,728	60.00
65.00	06500	RESPIRATORY THERAPY	-5,139	860,556	65.00
66.00	06600	PHYSICAL THERAPY	-397	889,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	48,840	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,940	68.00
69.00	06900	ELECTROCARDIOLOGY	-109,528	391,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-665	15,452	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-345	860,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-999	1,961,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-8,937	2,281,153	73.00
74.00	07400	RENAL DIALYSIS	0	259,986	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060	WOUND CARE	0	41,587	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-58,371	300,395	90.00
91.00	09100	EMERGENCY	-1,667,031	3,072,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	249,501	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	593,350	81,704,386	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	83,379	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-1,976,758	31,806	192.00
192.03	19203	OP PHARMACY	0	524,830	192.03
194.00	07950	FOUNDATION	0	203,928	194.00
194.01	07951	MARKETING	0	206,713	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,351,842	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,383,408	88,106,884	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0292

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

Worksheet Non-CMS W

Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	COMMUNICATIONS	01160	COMMUNICATIONS	5.01
5.04	ADMITTING	00570	ADMITTING	5.04
5.06	OTHER ADMINISTRATIVE AND GENERAL	00560	PURCHASING RECEIVING AND STORES	5.06
7.00	OPERATION OF PLANT	00700		7.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	BACTERIOLOGY & MICROBIOLOGY	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	WOUND CARE	03060	BIOPSY	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.03	OP PHARMACY	19203		192.03
194.00	FOUNDATION	07950		194.00
194.01	MARKETING	07951		194.01
194.03	THERAPEUTIC DAY SCHOOL	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	114,608	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
0			0	114,608	
B - CAFETERIA					
1.00	CAFETERIA	11.00	169	1,341,496	1.00
0			169	1,341,496	
C - NURSERY					
1.00	NURSERY	43.00	352,575	130,866	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	667,255	261,728	2.00
0			1,019,830	392,594	
D - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	125,735	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	524,148	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
0			0	649,883	
E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,517,011	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,813,767	2.00
0			0	3,330,778	
F - PSYCH ASSESSMENTS					
1.00	ADULTS & PEDIATRICS	30.00	387,128	0	1.00
2.00	SUBPROVIDER - IPF	40.00	0	46,916	2.00
0			387,128	46,916	
G - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,269,557	1.00
0			0	2,269,557	
H - RECRUITMENT					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	10,000	0	1.00
2.00	EMERGENCY	91.00	1,000	0	2.00
3.00	FOUNDATION	194.00	10,000	0	3.00
0			21,000	0	
I - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,159	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,400	2.00
0			0	55,559	
J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,380	1.00
0			0	8,380	
K - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,799	1.00
2.00		0.00	0	0	2.00
0			0	16,799	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
L - SHARED SERVICES					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,137,109	6,439,104	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	25,895	239,403	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	59,394	6,324	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,222,398	0	4.00
	0		4,444,796	6,684,831	
M - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	425,705	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	227,445	2.00
	0		0	653,150	
500.00	Grand Total: Increases		5,872,923	15,564,551	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - BILLABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	157	0	1.00	
2.00	RADIOISOTOPE	56.00	0	108,591	0	2.00	
3.00	LABORATORY	60.00	0	1	0	3.00	
4.00	PHYSICAL THERAPY	66.00	0	170	0	4.00	
5.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,689	0	5.00	
	0		0	114,608			
B - CAFETERIA							
1.00	DIETARY	10.00	169	1,341,496	0	1.00	
	0		169	1,341,496			
C - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	1,019,830	392,594	0	1.00	
2.00		0.00	0	0	0	2.00	
	0		1,019,830	392,594			
D - RENT AND LEASES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120	10	1.00	
2.00	COMMUNICATIONS	5.01	0	1,137	10	2.00	
3.00	ADMITTING	5.04	0	120	0	3.00	
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	5,325	0	4.00	
5.00	OPERATION OF PLANT	7.00	0	555	0	5.00	
6.00	HOUSEKEEPING	9.00	0	1,530	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	595	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	124,824	0	8.00	
9.00	PHARMACY	15.00	0	228,721	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	180	0	10.00	
11.00	SOCIAL SERVICE	17.00	0	120	0	11.00	
12.00	ADULTS & PEDIATRICS	30.00	0	19,017	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	0	75	0	13.00	
14.00	SUBPROVIDER - IPF	40.00	0	480	0	14.00	
15.00	OPERATING ROOM	50.00	0	4,949	0	15.00	
16.00	ANESTHESIOLOGY	53.00	0	120	0	16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	204	0	17.00	
18.00	MRI	58.00	0	120	0	18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	2,640	0	19.00	
20.00	LABORATORY	60.00	0	90,628	0	20.00	
21.00	RESPIRATORY THERAPY	65.00	0	11,962	0	21.00	
22.00	PHYSICAL THERAPY	66.00	0	127,883	0	22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	720	0	23.00	
24.00	CLINIC	90.00	0	27,638	0	24.00	
25.00	EMERGENCY	91.00	0	220	0	25.00	
	0		0	649,883			
E - DEPRECIATION							
1.00	INTEREST EXPENSE	113.00	0	3,330,778	9	1.00	
2.00		0.00	0	0	9	2.00	
	0		0	3,330,778			
F - PSYCH ASSESSMENTS							
1.00	ADULTS & PEDIATRICS	30.00	0	46,916	0	1.00	
2.00	SUBPROVIDER - IPF	40.00	387,128	0	0	2.00	
	0		387,128	46,916			
G - BILLABLE DRUGS							
1.00	PHARMACY	15.00	0	2,269,557	0	1.00	
	0		0	2,269,557			
H - RECRUITMENT							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	10,000	0	1.00	
2.00	EMERGENCY	91.00	0	1,000	0	2.00	
3.00	FOUNDATION	194.00	0	10,000	0	3.00	
	0		0	21,000			
I - INSURANCE							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	55,559	12	1.00	
2.00		0.00	0	0	12	2.00	
	0		0	55,559			
J - PROPERTY TAX							
1.00	INTEREST EXPENSE	113.00	0	8,380	13	1.00	
	0		0	8,380			
K - IMPLANTIBLES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,045	0	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,754	0	2.00	
	0		0	16,799			

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
L - SHARED SERVICES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,222,398	6,684,831		0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	2,222,398		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
	0		2,222,398	8,907,229			
M - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	653,150		11	1.00
2.00		0.00	0	0		11	2.00
	0		0	653,150			
500.00	Grand Total: Decreases		3,629,525	17,807,949			500.00

Increases				Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - BILLABLE SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	114,608	ADULTS & PEDIATRICS	30.00	0	157
2.00		0.00	0	0	RADIOISOTOPE	56.00	0	108,591
3.00		0.00	0	0	LABORATORY	60.00	0	1
4.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	170
5.00		0.00	0	0	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,689
0			0	114,608			0	114,608
B - CAFETERIA								
1.00	CAFETERIA	11.00	169	1,341,496	DIETARY	10.00	169	1,341,496
0			169	1,341,496			169	1,341,496
C - NURSERY								
1.00	NURSERY	43.00	352,575	130,866	ADULTS & PEDIATRICS	30.00	1,019,830	392,594
2.00	DELIVERY ROOM & LABOR ROOM	52.00	667,255	261,728		0.00	0	0
0			1,019,830	392,594			1,019,830	392,594
D - RENT AND LEASES								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	125,735	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	524,148	COMMUNICATIONS	5.01	0	1,137
3.00		0.00	0	0	ADMITTING	5.04	0	120
4.00		0.00	0	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	5,325
5.00		0.00	0	0	OPERATION OF PLANT	7.00	0	555
6.00		0.00	0	0	HOUSEKEEPING	9.00	0	1,530
7.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	595
8.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	124,824
9.00		0.00	0	0	PHARMACY	15.00	0	228,721
10.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	180
11.00		0.00	0	0	SOCIAL SERVICE	17.00	0	120
12.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	19,017
13.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	75
14.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	480
15.00		0.00	0	0	OPERATING ROOM	50.00	0	4,949
16.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	120
17.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	204
18.00		0.00	0	0	MRI	58.00	0	120
19.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	2,640
20.00		0.00	0	0	LABORATORY	60.00	0	90,628
21.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	11,962
22.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	127,883
23.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	720
24.00		0.00	0	0	CLINIC	90.00	0	27,638
25.00		0.00	0	0	EMERGENCY	91.00	0	220
0			0	649,883			0	649,883
E - DEPRECIATION								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,517,011	INTEREST EXPENSE	113.00	0	3,330,778
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,813,767		0.00	0	0
0			0	3,330,778			0	3,330,778
F - PSYCH ASSESSMENTS								
1.00	ADULTS & PEDIATRICS	30.00	387,128	0	ADULTS & PEDIATRICS	30.00	0	46,916
2.00	SUBPROVIDER - IPF	40.00	0	46,916	SUBPROVIDER - IPF	40.00	387,128	0
0			387,128	46,916			387,128	46,916
G - BILLABLE DRUGS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,269,557	PHARMACY	15.00	0	2,269,557
0			0	2,269,557			0	2,269,557
H - RECRUITMENT								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	10,000	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	10,000
2.00	EMERGENCY	91.00	1,000	0	EMERGENCY	91.00	0	1,000
3.00	FOUNDATION	194.00	10,000	0	FOUNDATION	194.00	0	10,000
0			21,000	0			0	21,000
I - INSURANCE								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,159	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	55,559

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00		4.00	5.00	6.00		8.00	9.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,400		0.00	0	0	2.00
	0		0	55,559			0	55,559	
J - PROPERTY TAX									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,380	INTEREST EXPENSE	113.00	0	8,380	1.00
	0		0	8,380			0	8,380	
K - IMPLANTIBLES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,799	CENTRAL SERVICES & SUPPLY	14.00	0	6,045	1.00
2.00		0.00	0	0	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,754	2.00
	0		0	16,799			0	16,799	
L - SHARED SERVICES									
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,137,109	6,439,104	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,222,398	6,684,831	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	25,895	239,403	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	2,222,398	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	59,394	6,324		0.00	0	0	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,222,398	0		0.00	0	0	4.00
	0		4,444,796	6,684,831			2,222,398	8,907,229	
M - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	425,705	INTEREST EXPENSE	113.00	0	653,150	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	227,445		0.00	0	0	2.00
	0		0	653,150			0	653,150	
500.00	Grand Total: Increases		5,872,923	15,564,551	Grand Total: Decreases		3,629,525	17,807,949	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2017 9:20 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,869,112	0	0	0	1.00
2.00	Land Improvements	438,336	200	0	200	2.00
3.00	Buildings and Fixtures	26,830,005	9,065,333	0	9,065,333	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	7,943,886	0	0	0	5.00
6.00	Movable Equipment	14,630,592	2,999,805	0	2,999,805	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	51,711,931	12,065,338	0	12,065,338	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	51,711,931	12,065,338	0	12,065,338	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,869,112	0			1.00
2.00	Land Improvements	438,536	0			2.00
3.00	Buildings and Fixtures	35,895,338	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	7,845,911	0			5.00
6.00	Movable Equipment	17,630,397	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	63,679,294	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	63,679,294	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2017 9:20 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	46,096,898	0	46,096,898	0.723346	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,630,397	0	17,630,397	0.276654	0	2.00
3.00	Total (sum of lines 1-2)	63,727,295	0	63,727,295	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,586,191	125,735	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,043,400	524,148	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,629,591	649,883	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	411,894	51,159	8,380	0	2,183,359	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	224,543	4,400	0	0	2,796,491	2.00
3.00	Total (sum of lines 1-2)	636,437	55,559	8,380	0	4,979,850	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	wkst. A-7 Ref.	Ref.
				Cost Center	Line #			
				3.00	4.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-5,431	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,902	CAP REL COSTS-MVBLE EQUIP	2.00		11	2.00
3.00	Investment income - other (chapter 2)		0		0.00		0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-23,875	COMMUNICATIONS	5.01		0	7.00
8.00	Television and radio service (chapter 21)	A	-16,341	OPERATION OF PLANT	7.00		0	8.00
9.00	Parking lot (chapter 21)		0		0.00		0	9.00
10.00	Provider-based physician adjustment	A-8-2	-99,928				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	8,838,560				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	0	RESPIRATORY THERAPY	65.00			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00	Physicians' assistant		0		0.00		0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00
33.00	MISC REVENUE	B	80	ADMITTING	5.04		0	33.00

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
33.01 MISC REVENUE	B	-61,221	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.01
33.02 MISC REVENUE	B	-6,647	OPERATION OF PLANT	7.00		0 33.02
33.03 MISC REVENUE	B	-5,225	HOUSEKEEPING	9.00		0 33.03
33.04 MISC REVENUE	B	-348,918	DIETARY	10.00		0 33.04
33.05 MISC REVENUE	B	-5,116	MEDICAL RECORDS & LIBRARY	16.00		0 33.05
33.06 MISC REVENUE	B	-259	ADULTS & PEDIATRICS	30.00		0 33.06
33.07 MISC REVENUE	B	-981	OPERATING ROOM	50.00		0 33.07
33.08 MISC REVENUE	B	-1,364	RADIOLOGY-DIAGNOSTIC	54.00		0 33.08
33.09 MISC REVENUE	B	-729	CARDIAC CATHETERIZATION	59.00		0 33.09
33.10 MISC REVENUE	B	-210	LABORATORY	60.00		0 33.10
33.11 MISC REVENUE	B	-397	PHYSICAL THERAPY	66.00		0 33.11
33.12 MISC REVENUE	B	-3,483	ELECTROCARDIOLOGY	69.00		0 33.12
33.13 MISC REVENUE	B	-84	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0 33.13
33.14 MISC REVENUE	B	-1,017	DRUGS CHARGED TO PATIENTS	73.00		0 33.14
33.15 MISC REVENUE	B	-31,202	CLINIC	90.00		0 33.15
33.17 LEGAL	A	-8,056	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.17
33.18 LOBBYING	A	-40,984	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.18
33.19 NON ALLOW PHYSICIAN PAYMENTS	A	16,000	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.19
33.20 NON ALLOW PHYSICIAN PAYMENTS	A	-1,938	SOCIAL SERVICE	17.00		0 33.20
33.21 NON ALLOW PHYSICIAN PAYMENTS	A	-470,850	ADULTS & PEDIATRICS	30.00		0 33.21
33.22 NON ALLOW PHYSICIAN PAYMENTS	A	-79,000	RADIOLOGY-DIAGNOSTIC	54.00		0 33.22
33.23 NON ALLOW PHYSICIAN PAYMENTS	A	-103,840	CARDIAC CATHETERIZATION	59.00		0 33.23
33.24 NON ALLOW PHYSICIAN PAYMENTS	A	-1,378,000	EMERGENCY	91.00		0 33.24
33.25 NON ALLOW PHYSICIAN PAYMENTS	A	-1,976,758	PHYSICIANS' PRIVATE OFFICES	192.00		0 33.25
33.26 HOSPICE	A	-3,424	OPERATING ROOM	50.00		0 33.26
33.27 HOSPICE	A	-132	ANESTHESIOLOGY	53.00		0 33.27
33.28 HOSPICE	A	-505	RADIOLOGY-DIAGNOSTIC	54.00		0 33.28
33.29 HOSPICE	A	-1,522	LABORATORY	60.00		0 33.29
33.30 HOSPICE	A	-5,139	RESPIRATORY THERAPY	65.00		0 33.30
33.31 HOSPICE	A	-34	ELECTROCARDIOLOGY	69.00		0 33.31
33.32 HOSPICE	A	-665	ELECTROENCEPHALOGRAPHY	70.00		0 33.32
33.33 HOSPICE	A	-261	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0 33.33
33.34 HOSPICE	A	-999	IMPL. DEV. CHARGED TO PATIENTS	72.00		0 33.34
33.35 HOSPICE	A	-7,920	DRUGS CHARGED TO PATIENTS	73.00		0 33.35
33.36 HOSPICE	A	-346	EMERGENCY	91.00		0 33.36
33.37 HOSPICE	A	-39,552	ADULTS & PEDIATRICS	30.00		0 33.37
33.38 HOSPICE	A	-3,955	INTENSIVE CARE UNIT	31.00		0 33.38
33.39 RECRUITMENT	A	-1,000	EMERGENCY	91.00		0 33.39
33.40 PROPERTY TAX	A	-8,380	CAP REL COSTS-BLDG & FIXT	1.00		11 33.40
33.41 SPECIAL ADMIT	A	-68,625	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 33.41
33.43 NON ALLOWABLE BORROWING	A	-41,119	INTEREST EXPENSE	113.00		0 33.43
35.00 STATE ASSESSMENT	A	-4,437,378	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 35.00
37.00 NON ALLOW COLLECTION FEE	A	-49,765	ELECTROCARDIOLOGY	69.00		0 37.00
38.00 MALPRACTICE	A	-389,412	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 38.00
39.00 SPECIAL EVENTS	A	-739	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 39.00
41.00 SPECIAL EVENTS	A	-11,632	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 41.00
42.00 SPECIAL EVENTS	A	-5,180	NURSING ADMINISTRATION	13.00		0 42.00
43.00 INCOME TAX	A	-7,353	INTEREST EXPENSE	113.00		0 43.00
44.00 SELF INSURANCE	A	-160,895	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 44.00
45.00 NON ALLOWABLE OUTSIDE SERVICES	A	-29,675	OTHER ADMINISTRATIVE AND GENERAL	5.06		0 45.00
46.00 NON ALLOWABLE HOSPITALIST	A	-287,685	EMERGENCY	91.00		0 46.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,383,408				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.

Provider CCN: 14-0292

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

Worksheet A-8

Date/Time Prepared:
 5/24/2017 9:20 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		wkst. A-7 Ref.
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	5.00

(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: 14-0292

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2017 9:20 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	5.06	OTHER ADMINISTRATIVE AND GEN	AHS SHARED SERVICES	8,907,229	0
2.00	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	69,180	0
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	229,633	0
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	106,138	39,731
3.02	5.06	OTHER ADMINISTRATIVE AND GEN	AHS HOME OFFICE	3,951,588	4,440,763
4.00	15.00	PHARMACY	AHS HOME OFFICE	0	13,987
4.01	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	13,221	8,243
4.02	31.00	INTENSIVE CARE UNIT	AHS HOME OFFICE	0	233,678
4.03	113.00	INTEREST EXPENSE	AHS HOME OFFICE	694,268	396,295
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			13,971,257	5,132,697

* 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	AHS CORPORATE	100.00	AHS CORPORATE	0.00	6.00
7.00	B	SHARED SERVICE	0.00	SHARED SERVICE	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: 14-0292

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2017 9:20 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	8,907,229	0	1.00
2.00	69,180	9	2.00
3.00	229,633	9	3.00
3.01	66,407	0	3.01
3.02	-489,175	0	3.02
4.00	-13,987	0	4.00
4.01	4,978	0	4.01
4.02	-233,678	0	4.02
4.03	297,973	0	4.03
5.00	8,838,560		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	MANAGEMENT SVCS	6.00
7.00	FINANCIAL SVCS	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: 14-0292

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2017 9:20 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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	46	46	0	0	0	1.00
2.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	8,369	8,369	0	0	0	2.00
3.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	56,246	56,246	0	0	0	3.00
4.00	90.00	AGGREGATE-CLINIC	27,169	27,169	0	0	0	4.00
5.00	5.06	DR. A	2,000	0	2,000	138,700	22	5.00
6.00	5.06	DR. B	2,000	0	2,000	138,700	36	6.00
7.00	5.06	DR. C	1,200	0	1,200	138,700	18	7.00
8.00	5.06	DR. D	2,000	0	2,000	138,700	111	8.00
9.00	5.06	DR. E	2,000	0	2,000	138,700	34	9.00
10.00	5.06	DR. F	2,900	0	2,900	138,700	13	10.00
11.00	5.06	DR. G	1,000	1,000	0	0	0	11.00
12.00	5.06	DR. H	2,800	0	2,800	138,700	35	12.00
13.00	5.06	DR. I	1,000	0	1,000	138,700	15	13.00
14.00	5.06	DR. J	500	0	500	138,700	10	14.00
15.00	5.06	DR. K	2,000	0	2,000	138,700	18	15.00
16.00	5.06	DR. L	2,000	0	2,000	138,700	55	16.00
17.00	5.06	DR. M	3,000	0	3,000	138,700	26	17.00
18.00	5.06	DR. N	3,000	0	3,000	138,700	51	18.00
19.00	5.06	DR. O	2,000	2,000	0	0	0	19.00
200.00			121,230	94,830	26,400		444	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0	0	1.00
2.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	0	0	2.00
3.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	4.00
5.00	5.06	DR. A	1,467	73	0	0	0	5.00
6.00	5.06	DR. B	2,401	120	0	0	0	6.00
7.00	5.06	DR. C	1,200	60	0	0	0	7.00
8.00	5.06	DR. D	7,402	370	0	0	0	8.00
9.00	5.06	DR. E	2,267	113	0	0	0	9.00
10.00	5.06	DR. F	867	43	0	0	0	10.00
11.00	5.06	DR. G	0	0	0	0	0	11.00
12.00	5.06	DR. H	2,334	117	0	0	0	12.00
13.00	5.06	DR. I	1,000	50	0	0	0	13.00
14.00	5.06	DR. J	667	33	0	0	0	14.00
15.00	5.06	DR. K	1,200	60	0	0	0	15.00
16.00	5.06	DR. L	3,668	183	0	0	0	16.00
17.00	5.06	DR. M	1,734	87	0	0	0	17.00
18.00	5.06	DR. N	3,401	170	0	0	0	18.00
19.00	5.06	DR. O	0	0	0	0	0	19.00
200.00			29,608	1,479	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	46		1.00
2.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	8,369		2.00
3.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	56,246		3.00
4.00	90.00	AGGREGATE-CLINIC	0	0	0	27,169		4.00
5.00	5.06	DR. A	0	1,467	533	533		5.00
6.00	5.06	DR. B	0	2,401	0	0		6.00
7.00	5.06	DR. C	0	1,200	0	0		7.00
8.00	5.06	DR. D	0	7,402	0	0		8.00
9.00	5.06	DR. E	0	2,267	0	0		9.00
10.00	5.06	DR. F	0	867	2,033	2,033		10.00
11.00	5.06	DR. G	0	0	0	1,000		11.00
12.00	5.06	DR. H	0	2,334	466	466		12.00
13.00	5.06	DR. I	0	1,000	0	0		13.00
14.00	5.06	DR. J	0	667	0	0		14.00
15.00	5.06	DR. K	0	1,200	800	800		15.00
16.00	5.06	DR. L	0	3,668	0	0		16.00
17.00	5.06	DR. M	0	1,734	1,266	1,266		17.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0292

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

worksheet A-8-2

Date/Time Prepared:
5/24/2017 9:20 am

	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		
18.00	5.06	DR. N	0	3,401	0	0		18.00
19.00	5.06	DR. O	0	0	0	2,000		19.00
200.00			0	29,608	5,098	99,928		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,183,359	2,183,359			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,796,491		2,796,491		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,103,781	6,184	7,920	5,117,885	4.00
5.01 01160	COMMUNICATIONS	139,278	0	0	0	5.01
5.04 00570	ADMITTING	904,281	7,157	9,167	108,110	5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	24,963,240	49,391	63,261	629,214	5.06
7.00 00700	OPERATION OF PLANT	2,841,345	633,719	811,680	128,044	7.00
9.00 00900	HOUSEKEEPING	1,530,964	16,386	20,988	293	9.00
10.00 01000	DIETARY	434,960	57,167	73,220	14	10.00
11.00 01100	CAFETERIA	1,341,665	33,221	42,550	23	11.00
13.00 01300	NURSING ADMINISTRATION	1,166,303	7,760	9,940	132,461	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	623,307	65,963	84,487	40,362	14.00
15.00 01500	PHARMACY	1,714,393	23,049	29,522	215,110	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	419,440	14,949	19,147	44,509	16.00
17.00 01700	SOCIAL SERVICE	833,897	0	0	83,786	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,253,046	471,773	604,256	1,274,554	30.00
31.00 03100	INTENSIVE CARE UNIT	2,234,455	46,361	59,380	242,939	31.00
40.00 04000	SUBPROVIDER - IPF	1,956,743	73,971	94,743	237,729	40.00
43.00 04300	NURSERY	490,856	0	0	48,593	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,084,084	136,996	175,468	182,948	50.00
51.00 05100	RECOVERY ROOM	292,699	9,430	12,078	37,471	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	929,054	0	0	91,972	52.00
53.00 05300	ANESTHESIOLOGY	83,781	2,566	3,287	6,666	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,149,346	58,805	75,319	126,339	54.00
56.00 05600	RADIOISOTOPE	173,239	16,062	20,572	20,237	56.00
57.00 05700	CT SCAN	497,213	0	0	55,573	57.00
58.00 05800	MRI	191,186	20,205	25,879	23,088	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,019,331	24,657	31,581	88,406	59.00
60.00 06000	LABORATORY	2,348,728	38,616	49,460	183,702	60.00
65.00 06500	RESPIRATORY THERAPY	860,556	5,426	6,950	94,841	65.00
66.00 06600	PHYSICAL THERAPY	889,581	102,755	131,611	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	48,840	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	19,940	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	391,561	31,830	40,768	46,455	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	15,452	0	0	2,108	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	860,713	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,961,931	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,281,153	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	259,986	0	0	0	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03060	WOUND CARE	41,587	0	0	906	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	300,395	13,526	17,325	40,753	90.00
91.00 09100	EMERGENCY	3,072,226	120,548	154,400	331,643	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	81,704,386	2,088,473	2,674,959	4,518,849	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,379	0	0	7,866	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	31,806	15,459	19,800	0	192.00
192.03 19203	OP PHARMACY	524,830	2,334	2,990	20,891	192.03
194.00 07950	FOUNDATION	203,928	2,767	3,544	24,924	194.00
194.01 07951	MARKETING	206,713	3,679	4,712	0	194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	5,351,842	70,647	90,486	545,355	194.03
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	88,106,884	2,183,359	2,796,491	5,117,885	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
		5.04	5A.04	5.06	7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570	1,028,715					5.04
5.06	00560	0	25,805,861	25,805,861			5.06
7.00	00700	0	4,414,788	1,828,658	6,243,446		7.00
9.00	00900	0	1,568,631	649,746	68,805	2,287,182	9.00
10.00	01000	0	565,361	234,179	240,040	88,915	10.00
11.00	01100	0	1,417,459	587,129	139,493	51,670	11.00
13.00	01300	0	1,316,464	545,295	32,585	12,070	13.00
14.00	01400	0	814,119	337,218	276,974	102,596	14.00
15.00	01500	0	1,982,074	820,999	96,782	35,850	15.00
16.00	01600	0	498,045	206,296	62,769	23,251	16.00
17.00	01700	0	917,683	380,115	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	144,548	12,779,696	5,293,532	1,980,949	733,773	30.00
31.00	03100	21,247	2,607,076	1,079,882	194,668	72,108	31.00
40.00	04000	27,881	2,395,377	992,194	310,598	115,050	40.00
43.00	04300	2,560	542,009	224,507	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	55,954	2,635,450	1,091,635	575,240	213,078	50.00
51.00	05100	9,178	360,856	149,471	39,596	14,667	51.00
52.00	05200	4,845	1,025,871	424,928	0	0	52.00
53.00	05300	15,236	111,536	46,200	10,775	3,991	53.00
54.00	05400	63,530	1,473,339	610,275	246,921	91,463	54.00
56.00	05600	12,885	242,995	100,651	67,442	24,982	56.00
57.00	05700	98,346	651,132	269,707	0	0	57.00
58.00	05800	19,646	280,004	115,981	84,838	31,425	58.00
59.00	05900	22,953	1,186,928	491,640	103,533	38,350	59.00
60.00	06000	137,422	2,757,928	1,142,367	162,147	60,062	60.00
65.00	06500	26,994	994,767	412,044	22,784	8,439	65.00
66.00	06600	15,343	1,139,290	471,908	431,462	159,820	66.00
67.00	06700	1,163	50,003	20,712	0	0	67.00
68.00	06800	1,300	21,240	8,798	0	0	68.00
69.00	06900	34,291	544,905	225,706	133,651	49,507	69.00
70.00	07000	924	18,484	7,656	0	0	70.00
71.00	07100	16,609	877,322	363,397	0	0	71.00
72.00	07200	30,401	1,992,332	825,248	0	0	72.00
73.00	07300	89,966	2,371,119	982,146	0	0	73.00
74.00	07400	2,189	262,175	108,596	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	279	42,772	17,717	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,412	380,411	157,571	56,797	21,038	90.00
91.00	09100	164,613	3,843,430	1,591,995	506,174	187,495	91.00
92.00	09200		0				92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,028,715	80,888,932	22,816,099	5,845,023	2,139,600	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	91,245	37,795	0	0	190.00
192.00	19200	0	67,065	27,779	64,911	24,044	192.00
192.03	19203	0	551,045	228,249	9,802	3,631	192.03
194.00	07950	0	235,163	97,407	11,619	4,304	194.00
194.01	07951	0	215,104	89,099	15,449	5,722	194.01
194.03	07953	0	6,058,330	2,509,433	296,642	109,881	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,028,715	88,106,884	25,805,861	6,243,446	2,287,182	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	1,128,495					10.00
11.00	01100	0	2,195,751				11.00
13.00	01300	0	66,154	1,972,568			13.00
14.00	01400	0	42,838	48,378	1,622,123		14.00
15.00	01500	0	102,110	115,315	10,100	3,163,230	15.00
16.00	01600	0	39,545	44,659	0	0	16.00
17.00	01700	0	44,543	50,303	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	862,192	806,949	911,298	158,442	18	30.00
31.00	03100	90,869	137,277	155,029	96,688	0	31.00
40.00	04000	175,434	147,224	166,262	13,627	0	40.00
43.00	04300	0	28,044	31,670	2,971	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	97,360	109,950	195,375	11,950	50.00
51.00	05100	0	13,953	15,758	1,547	0	51.00
52.00	05200	0	53,078	59,942	0	0	52.00
53.00	05300	0	6,253	7,062	10,367	4,395	53.00
54.00	05400	0	70,285	0	4,507	1,079	54.00
56.00	05600	0	8,959	0	44,445	174	56.00
57.00	05700	0	29,230	0	8,259	1,280	57.00
58.00	05800	0	10,876	0	1,237	28	58.00
59.00	05900	0	35,764	0	41,971	0	59.00
60.00	06000	0	123,709	0	14,308	0	60.00
65.00	06500	0	60,932	0	17,701	0	65.00
66.00	06600	0	0	0	964	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	27,639	0	2,727	18,592	69.00
70.00	07000	0	1,699	0	0	0	70.00
71.00	07100	0	0	0	284,883	0	71.00
72.00	07200	0	0	0	569,359	0	72.00
73.00	07300	0	0	0	0	2,703,866	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	681	0	155	9	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	24,793	27,999	7,346	2,813	90.00
91.00	09100	0	202,727	228,943	134,830	13,378	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,128,495	2,182,622	1,972,568	1,621,809	2,757,582	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	6,025	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	7,104	0	314	405,648	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,128,495	2,195,751	1,972,568	1,622,123	3,163,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	874,565				16.00
17.00	01700	SOCIAL SERVICE	0	1,392,644			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	122,901	1,040,960	24,690,710	0	24,690,710
31.00	03100	INTENSIVE CARE UNIT	18,065	109,709	4,561,371	0	4,561,371
40.00	04000	SUBPROVIDER - IPF	23,705	211,805	4,551,276	0	4,551,276
43.00	04300	NURSERY	2,177	30,170	861,548	0	861,548
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,575	0	4,977,613	0	4,977,613
51.00	05100	RECOVERY ROOM	7,804	0	603,652	0	603,652
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,120	0	1,567,939	0	1,567,939
53.00	05300	ANESTHESIOLOGY	12,954	0	213,533	0	213,533
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,016	0	2,551,885	0	2,551,885
56.00	05600	RADIOISOTOPE	10,956	0	500,604	0	500,604
57.00	05700	CT SCAN	83,618	0	1,043,226	0	1,043,226
58.00	05800	MRI	16,704	0	541,093	0	541,093
59.00	05900	CARDIAC CATHETERIZATION	19,515	0	1,917,701	0	1,917,701
60.00	06000	LABORATORY	116,842	0	4,377,363	0	4,377,363
65.00	06500	RESPIRATORY THERAPY	22,951	0	1,539,618	0	1,539,618
66.00	06600	PHYSICAL THERAPY	13,046	0	2,216,490	0	2,216,490
67.00	06700	OCCUPATIONAL THERAPY	989	0	71,704	0	71,704
68.00	06800	SPEECH PATHOLOGY	1,105	0	31,143	0	31,143
69.00	06900	ELECTROCARDIOLOGY	29,156	0	1,031,883	0	1,031,883
70.00	07000	ELECTROENCEPHALOGRAPHY	785	0	28,624	0	28,624
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,122	0	1,539,724	0	1,539,724
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,848	0	3,412,787	0	3,412,787
73.00	07300	DRUGS CHARGED TO PATIENTS	76,493	0	6,133,624	0	6,133,624
74.00	07400	RENAL DIALYSIS	1,861	0	372,632	0	372,632
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	237	0	61,571	0	61,571
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,153	0	685,921	0	685,921
91.00	09100	EMERGENCY	139,867	0	6,848,839	0	6,848,839
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	874,565	1,392,644	76,934,074	0	76,934,074
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	135,065	0	135,065
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	183,799	0	183,799
192.03	19203	OP PHARMACY	0	0	1,205,793	0	1,205,793
194.00	07950	FOUNDATION	0	0	348,493	0	348,493
194.01	07951	MARKETING	0	0	325,374	0	325,374
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	8,974,286	0	8,974,286
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	874,565	1,392,644	88,106,884	0	88,106,884

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.01	COMMUNICATIONS	2	NUMBER OF PHONES	5.01
5.04	ADMITTING	C	GROSS CHAR GES	5.04
5.06	OTHER ADMINISTRATIVE AND GENERAL	-1	ACCUM. COST	5.06
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	HOURS WORKED	11.00
13.00	NURSING ADMINISTRATION	5	DIRECT NRSGING	13.00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14.00
15.00	PHARMACY	7	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	8	TOTAL PATI ENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 9:20 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00				2.00
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,184	7,920	14,104	14,104	4.00
5.01	01160	COMMUNICATIONS	0	0	0	0	0	5.01
5.04	00570	ADMITTING	0	7,157	9,167	16,324	298	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	49,391	63,261	112,652	1,735	5.06
7.00	00700	OPERATION OF PLANT	0	633,719	811,680	1,445,399	353	7.00
9.00	00900	HOUSEKEEPING	0	16,386	20,988	37,374	1	9.00
10.00	01000	DIETARY	0	57,167	73,220	130,387	0	10.00
11.00	01100	CAFETERIA	0	33,221	42,550	75,771	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,760	9,940	17,700	365	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	65,963	84,487	150,450	111	14.00
15.00	01500	PHARMACY	0	23,049	29,522	52,571	593	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,949	19,147	34,096	123	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	231	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	471,773	604,256	1,076,029	3,509	30.00
31.00	03100	INTENSIVE CARE UNIT	0	46,361	59,380	105,741	670	31.00
40.00	04000	SUBPROVIDER - IPF	0	73,971	94,743	168,714	655	40.00
43.00	04300	NURSERY	0	0	0	0	134	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	136,996	175,468	312,464	504	50.00
51.00	05100	RECOVERY ROOM	0	9,430	12,078	21,508	103	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	254	52.00
53.00	05300	ANESTHESIOLOGY	0	2,566	3,287	5,853	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,805	75,319	134,124	348	54.00
56.00	05600	RADIOISOTOPE	0	16,062	20,572	36,634	56	56.00
57.00	05700	CT SCAN	0	0	0	0	153	57.00
58.00	05800	MRI	0	20,205	25,879	46,084	64	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,657	31,581	56,238	244	59.00
60.00	06000	LABORATORY	0	38,616	49,460	88,076	506	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,426	6,950	12,376	261	65.00
66.00	06600	PHYSICAL THERAPY	0	102,755	131,611	234,366	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	31,830	40,768	72,598	128	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	2	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	13,526	17,325	30,851	112	90.00
91.00	09100	EMERGENCY	0	120,548	154,400	274,948	914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,088,473	2,674,959	4,763,432	12,451	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,459	19,800	35,259	0	192.00
192.03	19203	OP PHARMACY	0	2,334	2,990	5,324	58	192.03
194.00	07950	FOUNDATION	0	2,767	3,544	6,311	69	194.00
194.01	07951	MARKETING	0	3,679	4,712	8,391	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	70,647	90,486	161,133	1,504	194.03
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)	0	2,183,359	2,796,491	4,979,850	14,104	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		COMMUNICATIONS	ADMITTING	OTHER	OPERATION OF	HOUSEKEEPING	
		5.01	5.04	ADMINISTRATIVE AND GENERAL 5.06	PLANT 7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160	0					5.01
5.04	00570	0	16,622				5.04
5.06	00560	0	0	114,387			5.06
7.00	00700	0	0	8,106	1,453,858		7.00
9.00	00900	0	0	2,880	16,022	56,277	9.00
10.00	01000	0	0	1,038	55,896	2,188	10.00
11.00	01100	0	0	2,602	32,483	1,271	11.00
13.00	01300	0	0	2,417	7,588	297	13.00
14.00	01400	0	0	1,495	64,497	2,524	14.00
15.00	01500	0	0	3,639	22,537	882	15.00
16.00	01600	0	0	914	14,616	572	16.00
17.00	01700	0	0	1,685	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	2,327	23,465	461,286	18,055	30.00
31.00	03100	0	342	4,787	45,331	1,774	31.00
40.00	04000	0	449	4,398	72,326	2,831	40.00
43.00	04300	0	41	995	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	901	4,839	133,951	5,243	50.00
51.00	05100	0	148	663	9,220	361	51.00
52.00	05200	0	78	1,883	0	0	52.00
53.00	05300	0	245	205	2,509	98	53.00
54.00	05400	0	1,023	2,705	57,498	2,250	54.00
56.00	05600	0	207	446	15,705	615	56.00
57.00	05700	0	1,583	1,195	0	0	57.00
58.00	05800	0	316	514	19,756	773	58.00
59.00	05900	0	369	2,179	24,109	944	59.00
60.00	06000	0	2,212	5,064	37,758	1,478	60.00
65.00	06500	0	435	1,826	5,305	208	65.00
66.00	06600	0	247	2,092	100,471	3,932	66.00
67.00	06700	0	19	92	0	0	67.00
68.00	06800	0	21	39	0	0	68.00
69.00	06900	0	552	1,000	31,122	1,218	69.00
70.00	07000	0	15	34	0	0	70.00
71.00	07100	0	267	1,611	0	0	71.00
72.00	07200	0	489	3,658	0	0	72.00
73.00	07300	0	1,448	4,353	0	0	73.00
74.00	07400	0	35	481	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	4	79	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	135	698	13,226	518	90.00
91.00	09100	0	2,714	7,057	117,869	4,613	91.00
92.00	09200	0					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	16,622	101,134	1,361,081	52,645	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	168	0	0	190.00
192.00	19200	0	0	123	15,115	592	192.00
192.03	19203	0	0	1,012	2,282	89	192.03
194.00	07950	0	0	432	2,706	106	194.00
194.01	07951	0	0	395	3,597	141	194.01
194.03	07953	0	0	11,123	69,077	2,704	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	16,622	114,387	1,453,858	56,277	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	189,509					10.00
11.00	01100	0	112,127				11.00
13.00	01300	0	3,378	31,745			13.00
14.00	01400	0	2,188	779	222,044		14.00
15.00	01500	0	5,214	1,856	1,383	88,675	15.00
16.00	01600	0	2,019	719	0	0	16.00
17.00	01700	0	2,275	810	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	144,788	41,208	14,663	21,688	1	30.00
31.00	03100	15,260	7,010	2,495	13,235	0	31.00
40.00	04000	29,461	7,518	2,676	1,865	0	40.00
43.00	04300	0	1,432	510	407	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	4,972	1,769	26,744	335	50.00
51.00	05100	0	713	254	212	0	51.00
52.00	05200	0	2,710	965	0	0	52.00
53.00	05300	0	319	114	1,419	123	53.00
54.00	05400	0	3,589	0	617	30	54.00
56.00	05600	0	457	0	6,084	5	56.00
57.00	05700	0	1,493	0	1,131	36	57.00
58.00	05800	0	555	0	169	1	58.00
59.00	05900	0	1,826	0	5,745	0	59.00
60.00	06000	0	6,317	0	1,959	0	60.00
65.00	06500	0	3,112	0	2,423	0	65.00
66.00	06600	0	0	0	132	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1,411	0	373	521	69.00
70.00	07000	0	87	0	0	0	70.00
71.00	07100	0	0	0	38,996	0	71.00
72.00	07200	0	0	0	77,936	0	72.00
73.00	07300	0	0	0	0	75,798	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	35	0	21	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	1,266	451	1,006	79	90.00
91.00	09100	0	10,352	3,684	18,456	375	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		189,509	111,456	31,745	222,001	77,304	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	308	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	363	0	43	11,371	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		189,509	112,127	31,745	222,044	88,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	53,059				16.00
17.00	01700	SOCIAL SERVICE	0	5,001			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,439	3,738	1,818,196	0	1,818,196
31.00	03100	INTENSIVE CARE UNIT	1,093	394	198,132	0	198,132
40.00	04000	SUBPROVIDER - IPF	1,435	761	293,089	0	293,089
43.00	04300	NURSERY	132	108	3,759	0	3,759
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,880	0	494,602	0	494,602
51.00	05100	RECOVERY ROOM	472	0	33,654	0	33,654
52.00	05200	DELIVERY ROOM & LABOR ROOM	249	0	6,139	0	6,139
53.00	05300	ANESTHESIOLOGY	784	0	11,687	0	11,687
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,269	0	205,453	0	205,453
56.00	05600	RADIOISOTOPE	663	0	60,872	0	60,872
57.00	05700	CT SCAN	5,061	0	10,652	0	10,652
58.00	05800	MRI	1,011	0	69,243	0	69,243
59.00	05900	CARDIAC CATHETERIZATION	1,181	0	92,835	0	92,835
60.00	06000	LABORATORY	7,072	0	150,442	0	150,442
65.00	06500	RESPIRATORY THERAPY	1,389	0	27,335	0	27,335
66.00	06600	PHYSICAL THERAPY	790	0	342,030	0	342,030
67.00	06700	OCCUPATIONAL THERAPY	60	0	171	0	171
68.00	06800	SPEECH PATHOLOGY	67	0	127	0	127
69.00	06900	ELECTROCARDIOLOGY	1,765	0	110,688	0	110,688
70.00	07000	ELECTROENCEPHALOGRAPHY	48	0	190	0	190
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	855	0	41,729	0	41,729
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,565	0	83,648	0	83,648
73.00	07300	DRUGS CHARGED TO PATIENTS	4,630	0	86,229	0	86,229
74.00	07400	RENAL DIALYSIS	113	0	629	0	629
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	14	0	155	0	155
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	433	0	48,775	0	48,775
91.00	09100	EMERGENCY	8,589	0	449,571	0	449,571
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,059	5,001	4,640,032	0	4,640,032
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	498	0	498
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	51,089	0	51,089
192.03	19203	OP PHARMACY	0	0	20,542	0	20,542
194.00	07950	FOUNDATION	0	0	9,624	0	9,624
194.01	07951	MARKETING	0	0	12,524	0	12,524
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	245,541	0	245,541
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	53,059	5,001	4,979,850	0	4,979,850

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	141,237				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		141,237			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	400	400	37,133,898		4.00
5.01 01160	COMMUNICATIONS	0	0	0	517	5.01
5.04 00570	ADMITTING	463	463	784,414	0	250,896,866 5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	3,195	3,195	4,565,411	374	0 5.06
7.00 00700	OPERATION OF PLANT	40,994	40,994	929,055	0	0 7.00
9.00 00900	HOUSEKEEPING	1,060	1,060	2,124	0	0 9.00
10.00 01000	DIETARY	3,698	3,698	99	0	0 10.00
11.00 01100	CAFETERIA	2,149	2,149	169	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	502	502	961,102	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,267	4,267	292,853	0	0 14.00
15.00 01500	PHARMACY	1,491	1,491	1,560,782	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	967	967	322,942	0	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	607,930	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	30,518	30,518	9,247,713	117	35,255,512 30.00
31.00 03100	INTENSIVE CARE UNIT	2,999	2,999	1,762,704	10	5,182,095 31.00
40.00 04000	SUBPROVIDER - IPF	4,785	4,785	1,724,899	16	6,800,160 40.00
43.00 04300	NURSERY	0	0	352,575	0	624,400 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,862	8,862	1,327,421	0	13,647,402 50.00
51.00 05100	RECOVERY ROOM	610	610	271,882	0	2,238,645 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	667,326	0	1,181,815 52.00
53.00 05300	ANESTHESIOLOGY	166	166	48,367	0	3,716,130 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,804	3,804	916,684	0	15,495,187 54.00
56.00 05600	RADIOISOTOPE	1,039	1,039	146,833	0	3,142,800 56.00
57.00 05700	CT SCAN	0	0	403,222	0	23,986,826 57.00
58.00 05800	MRI	1,307	1,307	167,524	0	4,791,800 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,595	1,595	641,449	0	5,598,202 59.00
60.00 06000	LABORATORY	2,498	2,498	1,332,893	0	33,517,540 60.00
65.00 06500	RESPIRATORY THERAPY	351	351	688,138	0	6,583,783 65.00
66.00 06600	PHYSICAL THERAPY	6,647	6,647	0	0	3,742,306 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	283,773 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	317,103 68.00
69.00 06900	ELECTROCARDIOLOGY	2,059	2,059	337,068	0	8,363,622 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	15,292	0	225,250 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,050,986 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,414,867 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	21,943,007 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	533,800 74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0 76.00
76.01 03060	WOUND CARE	0	0	6,575	0	68,035 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	875	875	295,693	0	2,051,790 90.00
91.00 09100	EMERGENCY	7,798	7,798	2,406,314	0	40,140,030 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	135,099	135,099	32,787,453	517	250,896,866 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	57,076	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,000	1,000	0	0	0 192.00
192.03 19203	OP PHARMACY	151	151	151,581	0	0 192.03
194.00 07950	FOUNDATION	179	179	180,839	0	0 194.00
194.01 07951	MARKETING	238	238	0	0	0 194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	4,570	4,570	3,956,949	0	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	2,183,359	2,796,491	5,117,885	139,278	1,028,715 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	15.458832	19.799989	0.137822	269.396518	0.004100 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			14,104	0	16,622 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000380	0.000000	0.000066 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.06	5.06	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-25,805,861	62,301,023			5.06
7.00	00700	OPERATION OF PLANT	0	4,414,788	96,185		7.00
9.00	00900	HOUSEKEEPING	0	1,568,631	1,060	95,125	9.00
10.00	01000	DIETARY	0	565,361	3,698	3,698	116,700
11.00	01100	CAFETERIA	0	1,417,459	2,149	2,149	0
13.00	01300	NURSING ADMINISTRATION	0	1,316,464	502	502	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	814,119	4,267	4,267	0
15.00	01500	PHARMACY	0	1,982,074	1,491	1,491	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	498,045	967	967	0
17.00	01700	SOCIAL SERVICE	0	917,683	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	12,779,696	30,518	30,518	89,161
31.00	03100	INTENSIVE CARE UNIT	0	2,607,076	2,999	2,999	9,397
40.00	04000	SUBPROVIDER - IPF	0	2,395,377	4,785	4,785	18,142
43.00	04300	NURSERY	0	542,009	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,635,450	8,862	8,862	0
51.00	05100	RECOVERY ROOM	0	360,856	610	610	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,025,871	0	0	0
53.00	05300	ANESTHESIOLOGY	0	111,536	166	166	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,473,339	3,804	3,804	0
56.00	05600	RADIOISOTOPE	0	242,995	1,039	1,039	0
57.00	05700	CT SCAN	0	651,132	0	0	0
58.00	05800	MRI	0	280,004	1,307	1,307	0
59.00	05900	CARDIAC CATHETERIZATION	0	1,186,928	1,595	1,595	0
60.00	06000	LABORATORY	0	2,757,928	2,498	2,498	0
65.00	06500	RESPIRATORY THERAPY	0	994,767	351	351	0
66.00	06600	PHYSICAL THERAPY	0	1,139,290	6,647	6,647	0
67.00	06700	OCCUPATIONAL THERAPY	0	50,003	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	21,240	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	544,905	2,059	2,059	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	18,484	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	877,322	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,992,332	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,371,119	0	0	0
74.00	07400	RENAL DIALYSIS	0	262,175	0	0	0
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	0	42,772	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	380,411	875	875	0
91.00	09100	EMERGENCY	0	3,843,430	7,798	7,798	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-25,805,861	55,083,071	90,047	88,987	116,700
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	91,245	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	67,065	1,000	1,000	0
192.03	19203	OP PHARMACY	0	551,045	151	151	0
194.00	07950	FOUNDATION	0	235,163	179	179	0
194.01	07951	MARKETING	0	215,104	238	238	0
194.03	07953	THERAPEUTIC DAY SCHOOL	0	6,058,330	4,570	4,570	0
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)		25,805,861	6,243,446	2,287,182	1,128,495
203.00		Unit cost multiplier (wkst. B, Part I)		0.414212	64.910807	24.043963	9.670051
204.00		Cost to be allocated (per wkst. B, Part II)		114,387	1,453,858	56,277	189,509
205.00		Unit cost multiplier (wkst. B, Part II)		0.001836	15.115226	0.591611	1.623899

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	673,518					11.00
13.00	01300	20,292	535,776				13.00
14.00	01400	13,140	13,140	4,048,320			14.00
15.00	01500	31,321	31,321	25,207	2,598,057		15.00
16.00	01600	12,130	12,130	0	0	250,896,866	16.00
17.00	01700	13,663	13,663	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	247,521	247,521	395,422	15	35,255,512	30.00
31.00	03100	42,108	42,108	241,303	0	5,182,095	31.00
40.00	04000	45,159	45,159	34,010	0	6,800,160	40.00
43.00	04300	8,602	8,602	7,415	0	624,400	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	29,864	29,864	487,597	9,815	13,647,402	50.00
51.00	05100	4,280	4,280	3,862	0	2,238,645	51.00
52.00	05200	16,281	16,281	0	0	1,181,815	52.00
53.00	05300	1,918	1,918	25,874	3,610	3,716,130	53.00
54.00	05400	21,559	0	11,248	886	15,495,187	54.00
56.00	05600	2,748	0	110,921	143	3,142,800	56.00
57.00	05700	8,966	0	20,612	1,051	23,986,826	57.00
58.00	05800	3,336	0	3,087	23	4,791,800	58.00
59.00	05900	10,970	0	104,748	0	5,598,202	59.00
60.00	06000	37,946	0	35,708	0	33,517,540	60.00
65.00	06500	18,690	0	44,177	0	6,583,783	65.00
66.00	06600	0	0	2,405	0	3,742,306	66.00
67.00	06700	0	0	0	0	283,773	67.00
68.00	06800	0	0	0	0	317,103	68.00
69.00	06900	8,478	0	6,807	15,270	8,363,622	69.00
70.00	07000	521	0	0	0	225,250	70.00
71.00	07100	0	0	710,982	0	4,050,986	71.00
72.00	07200	0	0	1,420,937	0	7,414,867	72.00
73.00	07300	0	0	0	2,220,768	21,943,007	73.00
74.00	07400	0	0	0	0	533,800	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	209	0	386	7	68,035	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	7,605	7,605	18,333	2,310	2,051,790	90.00
91.00	09100	62,184	62,184	336,495	10,988	40,140,030	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		669,491	535,776	4,047,536	2,264,886	250,896,866	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,848	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	2,179	0	784	333,171	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		2,195,751	1,972,568	1,622,123	3,163,230	874,565	202.00
203.00		3.260122	3.681703	0.400690	1.217537	0.003486	203.00
204.00		112,127	31,745	222,044	88,675	53,059	204.00
205.00		0.166480	0.059251	0.054848	0.034131	0.000211	205.00

Cost Center Description		SOCIAL SERVICE	
		(TOTAL PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	01160	COMMUNICATIONS	5.01
5.04	00570	ADMITTING	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03060	WOUND CARE	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.03	19203	OP PHARMACY	192.03
194.00	07950	FOUNDATION	194.00
194.01	07951	MARKETING	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per wkst. B, Part I)	202.00
		1,392,644	
203.00		Unit cost multiplier (wkst. B, Part I)	203.00
		47.288421	
204.00		Cost to be allocated (per wkst. B, Part II)	204.00
		5,001	
205.00		Unit cost multiplier (wkst. B, Part II)	205.00
		0.169813	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 9:20 am

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,690,710		24,690,710	0	24,690,710	30.00
31.00	03100	INTENSIVE CARE UNIT	4,561,371		4,561,371	0	4,561,371	31.00
40.00	04000	SUBPROVIDER - IPF	4,551,276		4,551,276	0	4,551,276	40.00
43.00	04300	NURSERY	861,548		861,548	0	861,548	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,977,613		4,977,613	0	4,977,613	50.00
51.00	05100	RECOVERY ROOM	603,652		603,652	0	603,652	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,567,939		1,567,939	0	1,567,939	52.00
53.00	05300	ANESTHESIOLOGY	213,533		213,533	0	213,533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,551,885		2,551,885	0	2,551,885	54.00
56.00	05600	RADIOISOTOPE	500,604		500,604	0	500,604	56.00
57.00	05700	CT SCAN	1,043,226		1,043,226	0	1,043,226	57.00
58.00	05800	MRI	541,093		541,093	0	541,093	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,917,701		1,917,701	0	1,917,701	59.00
60.00	06000	LABORATORY	4,377,363		4,377,363	0	4,377,363	60.00
65.00	06500	RESPIRATORY THERAPY	1,539,618	0	1,539,618	0	1,539,618	65.00
66.00	06600	PHYSICAL THERAPY	2,216,490	0	2,216,490	0	2,216,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,704	0	71,704	0	71,704	67.00
68.00	06800	SPEECH PATHOLOGY	31,143	0	31,143	0	31,143	68.00
69.00	06900	ELECTROCARDIOLOGY	1,031,883		1,031,883	0	1,031,883	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28,624		28,624	0	28,624	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,539,724		1,539,724	0	1,539,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,412,787		3,412,787	0	3,412,787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,133,624		6,133,624	0	6,133,624	73.00
74.00	07400	RENAL DIALYSIS	372,632		372,632	0	372,632	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03060	WOUND CARE	61,571		61,571	0	61,571	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	685,921		685,921	0	685,921	90.00
91.00	09100	EMERGENCY	6,848,839		6,848,839	0	6,848,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,982,678		1,982,678	0	1,982,678	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	78,916,752	0	78,916,752	0	78,916,752	200.00
201.00		Less Observation Beds	1,982,678		1,982,678		1,982,678	201.00
202.00		Total (see instructions)	76,934,074	0	76,934,074	0	76,934,074	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 9:20 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	31,097,799		31,097,799		30.00
31.00	03100	INTENSIVE CARE UNIT	5,182,095		5,182,095		31.00
40.00	04000	SUBPROVIDER - IPF	6,800,160		6,800,160		40.00
43.00	04300	NURSERY	624,400		624,400		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,648,415	8,998,987	13,647,402	0.364730	50.00
51.00	05100	RECOVERY ROOM	626,790	1,611,855	2,238,645	0.269651	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,084,000	97,815	1,181,815	1.326721	52.00
53.00	05300	ANESTHESIOLOGY	1,461,820	2,254,310	3,716,130	0.057461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,450	10,992,737	15,495,187	0.164689	54.00
56.00	05600	RADIOISOTOPE	981,700	2,161,100	3,142,800	0.159286	56.00
57.00	05700	CT SCAN	7,611,475	16,375,351	23,986,826	0.043492	57.00
58.00	05800	MRI	1,733,600	3,058,200	4,791,800	0.112921	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,870,700	1,727,502	5,598,202	0.342557	59.00
60.00	06000	LABORATORY	19,677,967	13,839,573	33,517,540	0.130599	60.00
65.00	06500	RESPIRATORY THERAPY	6,058,906	524,877	6,583,783	0.233850	65.00
66.00	06600	PHYSICAL THERAPY	721,438	3,020,868	3,742,306	0.592279	66.00
67.00	06700	OCCUPATIONAL THERAPY	263,769	20,004	283,773	0.252681	67.00
68.00	06800	SPEECH PATHOLOGY	299,052	18,051	317,103	0.098211	68.00
69.00	06900	ELECTROCARDIOLOGY	4,430,203	3,933,419	8,363,622	0.123378	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,750	42,500	225,250	0.127077	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,613,498	2,437,488	4,050,986	0.380086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,313,408	4,101,459	7,414,867	0.460263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,185,027	7,757,980	21,943,007	0.279525	73.00
74.00	07400	RENAL DIALYSIS	533,800	0	533,800	0.698074	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	68,035	68,035	0.904990	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	38,200	2,013,590	2,051,790	0.334304	90.00
91.00	09100	EMERGENCY	8,796,780	31,343,250	40,140,030	0.170624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	843,345	3,314,368	4,157,713	0.476867	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	131,183,547	119,713,319	250,896,866		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	131,183,547	119,713,319	250,896,866		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.364730			50.00
51.00	05100 RECOVERY ROOM	0.269651			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.326721			52.00
53.00	05300 ANESTHESIOLOGY	0.057461			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.164689			54.00
56.00	05600 RADIOISOTOPE	0.159286			56.00
57.00	05700 CT SCAN	0.043492			57.00
58.00	05800 MRI	0.112921			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.342557			59.00
60.00	06000 LABORATORY	0.130599			60.00
65.00	06500 RESPIRATORY THERAPY	0.233850			65.00
66.00	06600 PHYSICAL THERAPY	0.592279			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.252681			67.00
68.00	06800 SPEECH PATHOLOGY	0.098211			68.00
69.00	06900 ELECTROCARDIOLOGY	0.123378			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.127077			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.380086			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.460263			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279525			73.00
74.00	07400 RENAL DIALYSIS	0.698074			74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000			76.00
76.01	03060 WOUND CARE	0.904990			76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.334304			90.00
91.00	09100 EMERGENCY	0.170624			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.476867			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 9:20 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
			Total Costs	RCE Disallowance		
			1.00	4.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	24,690,710		24,690,710	0	24,690,710 30.00
31.00	03100 INTENSIVE CARE UNIT	4,561,371		4,561,371	0	4,561,371 31.00
40.00	04000 SUBPROVIDER - IPF	4,551,276		4,551,276	0	4,551,276 40.00
43.00	04300 NURSERY	861,548		861,548	0	861,548 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4,977,613		4,977,613	0	4,977,613 50.00
51.00	05100 RECOVERY ROOM	603,652		603,652	0	603,652 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,567,939		1,567,939	0	1,567,939 52.00
53.00	05300 ANESTHESIOLOGY	213,533		213,533	0	213,533 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,551,885		2,551,885	0	2,551,885 54.00
56.00	05600 RADIOISOTOPE	500,604		500,604	0	500,604 56.00
57.00	05700 CT SCAN	1,043,226		1,043,226	0	1,043,226 57.00
58.00	05800 MRI	541,093		541,093	0	541,093 58.00
59.00	05900 CARDIAC CATHETERIZATION	1,917,701		1,917,701	0	1,917,701 59.00
60.00	06000 LABORATORY	4,377,363		4,377,363	0	4,377,363 60.00
65.00	06500 RESPIRATORY THERAPY	1,539,618	0	1,539,618	0	1,539,618 65.00
66.00	06600 PHYSICAL THERAPY	2,216,490	0	2,216,490	0	2,216,490 66.00
67.00	06700 OCCUPATIONAL THERAPY	71,704	0	71,704	0	71,704 67.00
68.00	06800 SPEECH PATHOLOGY	31,143	0	31,143	0	31,143 68.00
69.00	06900 ELECTROCARDIOLOGY	1,031,883		1,031,883	0	1,031,883 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	28,624		28,624	0	28,624 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,539,724		1,539,724	0	1,539,724 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,412,787		3,412,787	0	3,412,787 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,133,624		6,133,624	0	6,133,624 73.00
74.00	07400 RENAL DIALYSIS	372,632		372,632	0	372,632 74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0		0	0	0 76.00
76.01	03060 WOUND CARE	61,571		61,571	0	61,571 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	685,921		685,921	0	685,921 90.00
91.00	09100 EMERGENCY	6,848,839		6,848,839	0	6,848,839 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,982,678		1,982,678	0	1,982,678 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	78,916,752	0	78,916,752	0	78,916,752 200.00
201.00	Less Observation Beds	1,982,678		1,982,678		1,982,678 201.00
202.00	Total (see instructions)	76,934,074	0	76,934,074	0	76,934,074 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		Title XIX			Hospital	Cost		
		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	31,097,799		31,097,799			30.00
31.00	03100	INTENSIVE CARE UNIT	5,182,095		5,182,095			31.00
40.00	04000	SUBPROVIDER - IPF	6,800,160		6,800,160			40.00
43.00	04300	NURSERY	624,400		624,400			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,648,415	8,998,987	13,647,402	0.364730	0.364730	50.00
51.00	05100	RECOVERY ROOM	626,790	1,611,855	2,238,645	0.269651	0.269651	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,084,000	97,815	1,181,815	1.326721	1.326721	52.00
53.00	05300	ANESTHESIOLOGY	1,461,820	2,254,310	3,716,130	0.057461	0.057461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,450	10,992,737	15,495,187	0.164689	0.164689	54.00
56.00	05600	RADIOISOTOPE	981,700	2,161,100	3,142,800	0.159286	0.159286	56.00
57.00	05700	CT SCAN	7,611,475	16,375,351	23,986,826	0.043492	0.043492	57.00
58.00	05800	MRI	1,733,600	3,058,200	4,791,800	0.112921	0.112921	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,870,700	1,727,502	5,598,202	0.342557	0.342557	59.00
60.00	06000	LABORATORY	19,677,967	13,839,573	33,517,540	0.130599	0.130599	60.00
65.00	06500	RESPIRATORY THERAPY	6,058,906	524,877	6,583,783	0.233850	0.233850	65.00
66.00	06600	PHYSICAL THERAPY	721,438	3,020,868	3,742,306	0.592279	0.592279	66.00
67.00	06700	OCCUPATIONAL THERAPY	263,769	20,004	283,773	0.252681	0.252681	67.00
68.00	06800	SPEECH PATHOLOGY	299,052	18,051	317,103	0.098211	0.098211	68.00
69.00	06900	ELECTROCARDIOLOGY	4,430,203	3,933,419	8,363,622	0.123378	0.123378	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,750	42,500	225,250	0.127077	0.127077	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,613,498	2,437,488	4,050,986	0.380086	0.380086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,313,408	4,101,459	7,414,867	0.460263	0.460263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,185,027	7,757,980	21,943,007	0.279525	0.279525	73.00
74.00	07400	RENAL DIALYSIS	533,800	0	533,800	0.698074	0.698074	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	0.000000	76.00
76.01	03060	WOUND CARE	0	68,035	68,035	0.904990	0.904990	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	38,200	2,013,590	2,051,790	0.334304	0.334304	90.00
91.00	09100	EMERGENCY	8,796,780	31,343,250	40,140,030	0.170624	0.170624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	843,345	3,314,368	4,157,713	0.476867	0.476867	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	131,183,547	119,713,319	250,896,866			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	131,183,547	119,713,319	250,896,866			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000				30.00
	ADULTS & PEDIATRICS				
31.00	03100				31.00
	INTENSIVE CARE UNIT				
40.00	04000				40.00
	SUBPROVIDER - IPF				
43.00	04300				43.00
	NURSERY				
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0.000000			50.00
	OPERATING ROOM				
51.00	05100	0.000000			51.00
	RECOVERY ROOM				
52.00	05200	0.000000			52.00
	DELIVERY ROOM & LABOR ROOM				
53.00	05300	0.000000			53.00
	ANESTHESIOLOGY				
54.00	05400	0.000000			54.00
	RADIOLOGY-DIAGNOSTIC				
56.00	05600	0.000000			56.00
	RADIOISOTOPE				
57.00	05700	0.000000			57.00
	CT SCAN				
58.00	05800	0.000000			58.00
	MRI				
59.00	05900	0.000000			59.00
	CARDIAC CATHETERIZATION				
60.00	06000	0.000000			60.00
	LABORATORY				
65.00	06500	0.000000			65.00
	RESPIRATORY THERAPY				
66.00	06600	0.000000			66.00
	PHYSICAL THERAPY				
67.00	06700	0.000000			67.00
	OCCUPATIONAL THERAPY				
68.00	06800	0.000000			68.00
	SPEECH PATHOLOGY				
69.00	06900	0.000000			69.00
	ELECTROCARDIOLOGY				
70.00	07000	0.000000			70.00
	ELECTROENCEPHALOGRAPHY				
71.00	07100	0.000000			71.00
	MEDICAL SUPPLIES CHARGED TO PATIENT				
72.00	07200	0.000000			72.00
	IMPL. DEV. CHARGED TO PATIENTS				
73.00	07300	0.000000			73.00
	DRUGS CHARGED TO PATIENTS				
74.00	07400	0.000000			74.00
	RENAL DIALYSIS				
76.00	03050	0.000000			76.00
	BACTERIOLOGY & MICROBIOLOGY				
76.01	03060	0.000000			76.01
	WOUND CARE				
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0.000000			90.00
	CLINIC				
91.00	09100	0.000000			91.00
	EMERGENCY				
92.00	09200	0.000000			92.00
	OBSERVATION BEDS (NON-DISTINCT PART				
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
	INTEREST EXPENSE				
200.00					200.00
	Subtotal (see instructions)				
201.00					201.00
	Less Observation Beds				
202.00					202.00
	Total (see instructions)				

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0292

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

Worksheet D
Part I
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,818,196	0	1,818,196	23,935	75.96	30.00	
31.00	INTENSIVE CARE UNIT	198,132		198,132	2,320	85.40	31.00	
40.00	SUBPROVIDER - IPF	293,089	0	293,089	4,479	65.44	40.00	
43.00	NURSERY	3,759		3,759	638	5.89	43.00	
200.00	Total (lines 30-199)	2,313,176		2,313,176	31,372		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	6,388	485,232					30.00
31.00	INTENSIVE CARE UNIT	965	82,411					31.00
40.00	SUBPROVIDER - IPF	2,770	181,269					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	10,123	748,912					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0292

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

Worksheet D
Part II
Date/Time Prepared:
5/24/2017 9:20 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	494,602	13,647,402	0.036241	1,298,288	47,051	50.00
51.00	05100	RECOVERY ROOM	33,654	2,238,645	0.015033	204,585	3,076	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,139	1,181,815	0.005195	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,687	3,716,130	0.003145	386,216	1,215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,453	15,495,187	0.013259	1,800,489	23,873	54.00
56.00	05600	RADIOISOTOPE	60,872	3,142,800	0.019369	363,775	7,046	56.00
57.00	05700	CT SCAN	10,652	23,986,826	0.000444	2,754,425	1,223	57.00
58.00	05800	MRI	69,243	4,791,800	0.014450	531,736	7,684	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,835	5,598,202	0.016583	1,362,815	22,600	59.00
60.00	06000	LABORATORY	150,442	33,517,540	0.004488	6,655,196	29,869	60.00
65.00	06500	RESPIRATORY THERAPY	27,335	6,583,783	0.004152	2,687,737	11,159	65.00
66.00	06600	PHYSICAL THERAPY	342,030	3,742,306	0.091396	325,692	29,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	171	283,773	0.000603	115,370	70	67.00
68.00	06800	SPEECH PATHOLOGY	127	317,103	0.000401	150,484	60	68.00
69.00	06900	ELECTROCARDIOLOGY	110,688	8,363,622	0.013234	1,769,959	23,424	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190	225,250	0.000844	57,433	48	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,729	4,050,986	0.010301	517,789	5,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,648	7,414,867	0.011281	1,057,001	11,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,229	21,943,007	0.003930	4,895,092	19,238	73.00
74.00	07400	RENAL DIALYSIS	629	533,800	0.001178	208,632	246	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060	WOUND CARE	155	68,035	0.002278	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	48,775	2,051,790	0.023772	3,259	77	90.00
91.00	09100	EMERGENCY	449,571	40,140,030	0.011200	3,038,302	34,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	146,002	4,157,713	0.035116	392,400	13,780	92.00
200.00		Total (lines 50-199)	2,472,858	207,192,412		30,576,675	292,793	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 14-0292 Period: From 01/01/2016 To 12/31/2016 Worksheet D Part III Date/Time Prepared: 5/24/2017 9:20 am

Cost Center Description			Title XVIII			Hospital	PPS	Total Costs (sum of cols. 1 through 3, minus col. 4)
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,935	0.00	6,388	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,320	0.00	965	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,479	0.00	2,770	0	0	40.00
43.00	04300	NURSERY	638	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	31,372		10,123	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col. 4)		
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

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	13,647,402	0.000000	0.000000	1,298,288	50.00
51.00	05100	RECOVERY ROOM	0	2,238,645	0.000000	0.000000	204,585	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,181,815	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,716,130	0.000000	0.000000	386,216	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,495,187	0.000000	0.000000	1,800,489	54.00
56.00	05600	RADIOISOTOPE	0	3,142,800	0.000000	0.000000	363,775	56.00
57.00	05700	CT SCAN	0	23,986,826	0.000000	0.000000	2,754,425	57.00
58.00	05800	MRI	0	4,791,800	0.000000	0.000000	531,736	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,598,202	0.000000	0.000000	1,362,815	59.00
60.00	06000	LABORATORY	0	33,517,540	0.000000	0.000000	6,655,196	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,583,783	0.000000	0.000000	2,687,737	65.00
66.00	06600	PHYSICAL THERAPY	0	3,742,306	0.000000	0.000000	325,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	283,773	0.000000	0.000000	115,370	67.00
68.00	06800	SPEECH PATHOLOGY	0	317,103	0.000000	0.000000	150,484	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,363,622	0.000000	0.000000	1,769,959	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	225,250	0.000000	0.000000	57,433	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,050,986	0.000000	0.000000	517,789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,414,867	0.000000	0.000000	1,057,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,943,007	0.000000	0.000000	4,895,092	73.00
74.00	07400	RENAL DIALYSIS	0	533,800	0.000000	0.000000	208,632	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060	WOUND CARE	0	68,035	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,051,790	0.000000	0.000000	3,259	90.00
91.00	09100	EMERGENCY	0	40,140,030	0.000000	0.000000	3,038,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,157,713	0.000000	0.000000	392,400	92.00
200.00		Total (lines 50-199)	0	207,192,412			30,576,675	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
		11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,983,361	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	403,333	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	442,643	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,386,211	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	494,856	0	0	0	56.00
57.00	05700	CT SCAN	0	2,905,617	0	0	0	57.00
58.00	05800	MRI	0	715,368	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	404,086	0	0	0	59.00
60.00	06000	LABORATORY	0	1,424,167	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	119,710	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,198	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,302	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,385	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	874,420	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,632	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	547,387	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,185,200	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,695,584	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	51,073	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	181,264	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,364,394	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	699,525	0	0	0	92.00
200.00		Total (lines 50-199)	0	18,921,716	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
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 PATIENT	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0			76.00
76.01	03060 WOUND CARE	0	0			76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0292

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

Worksheet D
Part V
Date/Time Prepared:
5/24/2017 9:20 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
		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	0.364730	1,983,361	0	0	723,391	50.00
51.00	05100 RECOVERY ROOM	0.269651	403,333	0	0	108,759	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.326721	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.057461	442,643	0	0	25,435	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.164689	1,386,211	0	0	228,294	54.00
56.00	05600 RADIOISOTOPE	0.159286	494,856	0	0	78,824	56.00
57.00	05700 CT SCAN	0.043492	2,905,617	0	0	126,371	57.00
58.00	05800 MRI	0.112921	715,368	0	0	80,780	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.342557	404,086	0	0	138,422	59.00
60.00	06000 LABORATORY	0.130599	1,424,167	0	0	185,995	60.00
65.00	06500 RESPIRATORY THERAPY	0.233850	119,710	0	0	27,994	65.00
66.00	06600 PHYSICAL THERAPY	0.592279	26,198	0	0	15,517	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.252681	7,302	0	0	1,845	67.00
68.00	06800 SPEECH PATHOLOGY	0.098211	2,385	0	0	234	68.00
69.00	06900 ELECTROCARDIOLOGY	0.123378	874,420	0	0	107,884	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.127077	7,632	0	0	970	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.380086	547,387	0	0	208,054	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.460263	1,185,200	0	0	545,504	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279525	1,695,584	0	29,971	473,958	73.00
74.00	07400 RENAL DIALYSIS	0.698074	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03060 WOUND CARE	0.904990	51,073	0	0	46,221	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.334304	181,264	0	0	60,597	90.00
91.00	09100 EMERGENCY	0.170624	3,364,394	0	0	574,046	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.476867	699,525	0	0	333,580	92.00
200.00	Subtotal (see instructions)		18,921,716	0	29,971	4,092,675	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		18,921,716	0	29,971	4,092,675	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/24/2017 9:20 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
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 PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,378	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	8,378	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	8,378	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/24/2017 9:20 am		
Title XVIII				Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	494,602	13,647,402	0.036241	0	0	50.00
51.00	05100	RECOVERY ROOM	33,654	2,238,645	0.015033	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,139	1,181,815	0.005195	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,687	3,716,130	0.003145	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,453	15,495,187	0.013259	60,189	798	54.00
56.00	05600	RADIOISOTOPE	60,872	3,142,800	0.019369	0	0	56.00
57.00	05700	CT SCAN	10,652	23,986,826	0.000444	110,975	49	57.00
58.00	05800	MRI	69,243	4,791,800	0.014450	10,200	147	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,835	5,598,202	0.016583	0	0	59.00
60.00	06000	LABORATORY	150,442	33,517,540	0.004488	756,361	3,395	60.00
65.00	06500	RESPIRATORY THERAPY	27,335	6,583,783	0.004152	270,307	1,122	65.00
66.00	06600	PHYSICAL THERAPY	342,030	3,742,306	0.091396	29,436	2,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	171	283,773	0.000603	18,132	11	67.00
68.00	06800	SPEECH PATHOLOGY	127	317,103	0.000401	13,435	5	68.00
69.00	06900	ELECTROCARDIOLOGY	110,688	8,363,622	0.013234	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190	225,250	0.000844	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,729	4,050,986	0.010301	89	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,648	7,414,867	0.011281	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,229	21,943,007	0.003930	702,399	2,760	73.00
74.00	07400	RENAL DIALYSIS	629	533,800	0.001178	27,900	33	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060	WOUND CARE	155	68,035	0.002278	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	48,775	2,051,790	0.023772	0	0	90.00
91.00	09100	EMERGENCY	449,571	40,140,030	0.011200	128,950	1,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,157,713	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,326,856	207,192,412		2,128,373	12,455	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	5.00
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 9:20 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	13,647,402	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	2,238,645	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,181,815	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,716,130	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,495,187	0.000000	0.000000	60,189	54.00
56.00	05600 RADIOISOTOPE	0	3,142,800	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	23,986,826	0.000000	0.000000	110,975	57.00
58.00	05800 MRI	0	4,791,800	0.000000	0.000000	10,200	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,598,202	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	33,517,540	0.000000	0.000000	756,361	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,583,783	0.000000	0.000000	270,307	65.00
66.00	06600 PHYSICAL THERAPY	0	3,742,306	0.000000	0.000000	29,436	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	283,773	0.000000	0.000000	18,132	67.00
68.00	06800 SPEECH PATHOLOGY	0	317,103	0.000000	0.000000	13,435	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,363,622	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	225,250	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,050,986	0.000000	0.000000	89	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	7,414,867	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,943,007	0.000000	0.000000	702,399	73.00
74.00	07400 RENAL DIALYSIS	0	533,800	0.000000	0.000000	27,900	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060 WOUND CARE	0	68,035	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,051,790	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	40,140,030	0.000000	0.000000	128,950	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,157,713	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	207,192,412			2,128,373	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 9:20 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
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 PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/24/2017 9:20 am
Title XIX			Subprovider - IPF	Tefra

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	494,602	13,647,402	0.036241	0	0	50.00
51.00	05100 RECOVERY ROOM	33,654	2,238,645	0.015033	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,139	1,181,815	0.005195	0	0	52.00
53.00	05300 ANESTHESIOLOGY	11,687	3,716,130	0.003145	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	205,453	15,495,187	0.013259	0	0	54.00
56.00	05600 RADIOISOTOPE	60,872	3,142,800	0.019369	0	0	56.00
57.00	05700 CT SCAN	10,652	23,986,826	0.000444	0	0	57.00
58.00	05800 MRI	69,243	4,791,800	0.014450	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	92,835	5,598,202	0.016583	0	0	59.00
60.00	06000 LABORATORY	150,442	33,517,540	0.004488	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	27,335	6,583,783	0.004152	0	0	65.00
66.00	06600 PHYSICAL THERAPY	342,030	3,742,306	0.091396	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	171	283,773	0.000603	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	127	317,103	0.000401	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	110,688	8,363,622	0.013234	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	190	225,250	0.000844	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	41,729	4,050,986	0.010301	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	83,648	7,414,867	0.011281	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	86,229	21,943,007	0.003930	0	0	73.00
74.00	07400 RENAL DIALYSIS	629	533,800	0.001178	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060 WOUND CARE	155	68,035	0.002278	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	48,775	2,051,790	0.023772	0	0	90.00
91.00	09100 EMERGENCY	449,571	40,140,030	0.011200	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,157,713	0.000000	0	0	92.00
200.00	Total (lines 50-199)	2,326,856	207,192,412		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

		Title XIX			Subprovider - IPF	Tefra
Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700 CT SCAN	0	0	0	0	0 57.00
58.00	05800 MRI	0	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000 LABORATORY	0	0	0	0	0 60.00
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 PATIENT	0	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0 76.00
76.01	03060 WOUND CARE	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	0 90.00
91.00	09100 EMERGENCY	0	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00	Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 9:20 am
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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	13,647,402	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	2,238,645	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,181,815	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,716,130	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,495,187	0.000000	0.000000	0	54.00
56.00	05600 RADIOISOTOPE	0	3,142,800	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	23,986,826	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	4,791,800	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,598,202	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	33,517,540	0.000000	0.000000	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,583,783	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	3,742,306	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	283,773	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	317,103	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,363,622	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	225,250	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,050,986	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	7,414,867	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,943,007	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	533,800	0.000000	0.000000	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060 WOUND CARE	0	68,035	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,051,790	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	40,140,030	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,157,713	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	207,192,412			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2017 9:20 am

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 9:20 am
Title XIX		Subprovider - IPF	Tefra

Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
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 PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01 03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 9:20 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)			23,935 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			23,935 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)			22,013 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)			6,388 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)			24,690,710 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)			24,690,710 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)			24,690,710 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)			1,031.57 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,589,669 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			6,589,669 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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	4,561,371	2,320	1,966.11	965	1,897,296	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)					6,416,086	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,903,051	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)					567,643	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					292,793	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					860,436	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,042,615	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,922	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,031.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,982,678	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,818,196	24,690,710	0.073639	1,982,678	146,002	90.00
91.00 Nursing School cost	0	24,690,710	0.000000	1,982,678	0	91.00
92.00 Allied health cost	0	24,690,710	0.000000	1,982,678	0	92.00
93.00 All other Medical Education	0	24,690,710	0.000000	1,982,678	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 9:20 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,479	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,479	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,479	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,770	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,551,276	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,551,276	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,551,276	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)	1,016.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,814,708	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,814,708	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 9:20 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					439,067	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,253,775	
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					181,269	
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					12,455	
52.00	Total Program excludable cost (sum of lines 50 and 51)					193,724	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,060,051	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	
58.00	Bonus payment (see instructions)					0	
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	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	
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	
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	
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	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	
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	
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	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00	
77.00	Program capital-related costs (line 9 x line 76)					77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00	
81.00	Inpatient routine service cost per diem limitation					81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00	
83.00	Reasonable inpatient routine service costs (see instructions)					83.00	
84.00	Program inpatient ancillary services (see instructions)					84.00	
85.00	Utilization review - physician compensation (see instructions)					85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/24/2017 9:20 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	293,089	4,551,276	0.064397	0	0	90.00
91.00	Nursing School cost	0	4,551,276	0.000000	0	0	91.00
92.00	Allied health cost	0	4,551,276	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,551,276	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Component CCN: 14-S292

Date/Time Prepared:
5/24/2017 9:20 am

Title XIX

Subprovider -
IPF

Tefra

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,479	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,479	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,479	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)	57	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)	638	15.00
16.00	Nursery days (title V or XIX only)	190	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,551,276	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,551,276	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,551,276	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)	1,016.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	57,920	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)	57,920	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

Period: From 01/01/2016

Worksheet D-1

Component CCN: 14-5292

To 12/31/2016

Date/Time Prepared: 5/24/2017 9:20 am

Title XIX

Subprovider - IPF

Tefra

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					57,920	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					57,920	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					7	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)					-57,920	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D-1
Date/Time Prepared:
5/24/2017 9:20 am

Title XIX

Subprovider -
IPF

Tefra

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	4,551,276	0.000000	0	0	90.00
91.00 Nursing School cost	0	4,551,276	0.000000	0	0	91.00
92.00 Allied health cost	0	4,551,276	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,551,276	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0292

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

Worksheet D-3

Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		8,294,529		30.00
31.00	03100 INTENSIVE CARE UNIT		2,265,582		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.364730	1,298,288	473,525	50.00
51.00	05100 RECOVERY ROOM	0.269651	204,585	55,167	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.326721	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.057461	386,216	22,192	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.164689	1,800,489	296,521	54.00
56.00	05600 RADIOISOTOPE	0.159286	363,775	57,944	56.00
57.00	05700 CT SCAN	0.043492	2,754,425	119,795	57.00
58.00	05800 MRI	0.112921	531,736	60,044	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.342557	1,362,815	466,842	59.00
60.00	06000 LABORATORY	0.130599	6,655,196	869,162	60.00
65.00	06500 RESPIRATORY THERAPY	0.233850	2,687,737	628,527	65.00
66.00	06600 PHYSICAL THERAPY	0.592279	325,692	192,901	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.252681	115,370	29,152	67.00
68.00	06800 SPEECH PATHOLOGY	0.098211	150,484	14,779	68.00
69.00	06900 ELECTROCARDIOLOGY	0.123378	1,769,959	218,374	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.127077	57,433	7,298	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.380086	517,789	196,804	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.460263	1,057,001	486,498	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279525	4,895,092	1,368,301	73.00
74.00	07400 RENAL DIALYSIS	0.698074	208,632	145,641	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	0.904990	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.334304	3,259	1,089	90.00
91.00	09100 EMERGENCY	0.170624	3,038,302	518,407	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.476867	392,400	187,123	92.00
200.00	Total (sum of lines 50-94 and 96-98)		30,576,675	6,416,086	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)		30,576,675		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	worksheet D-3 Date/Time Prepared: 5/24/2017 9:20 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		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		4,218,320	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.364730	0	50.00
51.00	05100	RECOVERY ROOM	0.269651	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.326721	0	52.00
53.00	05300	ANESTHESIOLOGY	0.057461	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164689	60,189	54.00
56.00	05600	RADIOISOTOPE	0.159286	0	56.00
57.00	05700	CT SCAN	0.043492	110,975	57.00
58.00	05800	MRI	0.112921	10,200	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.342557	0	59.00
60.00	06000	LABORATORY	0.130599	756,361	60.00
65.00	06500	RESPIRATORY THERAPY	0.233850	270,307	65.00
66.00	06600	PHYSICAL THERAPY	0.592279	29,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.252681	18,132	67.00
68.00	06800	SPEECH PATHOLOGY	0.098211	13,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0.123378	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.127077	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.380086	89	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.460263	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279525	702,399	73.00
74.00	07400	RENAL DIALYSIS	0.698074	27,900	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	76.00
76.01	03060	WOUND CARE	0.904990	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.334304	0	90.00
91.00	09100	EMERGENCY	0.170624	128,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.476867	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,128,373	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)		2,128,373	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 9:20 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)			7,594,753 1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,604,305 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)			94,324 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)			121.60 4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000 21.00
22.00	IME payment adjustment (see instructions)			0 22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0 22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000 26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000 27.00
28.00	IME add-on adjustment amount (see instructions)			0 28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0 28.01
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0 29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			8.97 30.00
31.00	Percentage of Medicaid patient days (see instructions)			40.56 31.00
32.00	Sum of lines 30 and 31			49.53 32.00
33.00	Allowable disproportionate share percentage (see instructions)			30.08 33.00
34.00	Disproportionate share adjustment (see instructions)			766,970 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 9:20 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)		0.000291491	0.000283369	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,867,336	1,693,832	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,397,951	426,939	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,824,890		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		12,885,242		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		12,885,242		49.00
50.00	Payment for inpatient program capital (from wkst. L, Pt. I and Pt. II, as applicable)		910,785		50.00
51.00	Exception payment for inpatient program capital (wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,796,027		59.00
60.00	Primary payer payments		22,191		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,773,836		61.00
62.00	Deductibles billed to program beneficiaries		1,015,812		62.00
63.00	Coinsurance billed to program beneficiaries		97,244		63.00
64.00	Allowable bad debts (see instructions)		380,101		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		247,066		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		340,690		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,907,846		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.88	SCH or MDH volume decrease adjustment		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		6,130		70.93
70.94	HRR adjustment amount (see instructions)		-14,996		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0292

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

Worksheet E
Part A
Date/Time Prepared:
5/24/2017 9:20 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	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	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			12,898,980	71.00
71.01	Sequestration adjustment (see instructions)			257,980	71.01
72.00	Interim payments			12,556,682	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)			84,318	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			554,463	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 DSH PAYMENT PERCENTAGE

Provider CCN: 14-0292

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

Worksheet DSH
Date/Time Prepared:
5/24/2017 9:20 am

		Title XVIII		Hospital		PPS	
		Original .mcrx values	Adjusted .mcax values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	8.97	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	40.56	0.00			40.56	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	49.53	0.00			40.56	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	121.60	0.00			121.60	5.00
6.00	Disproportionate Share Payment Percentage (transferred from worksheet E, Part A, line 33)	30.08	0.00			22.68	6.00
7.00	Qualify for operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	8.97	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (worksheet S-2, line 24, column 1)	2,487	0			2,487	15.00
16.00	In-State Medicaid eligible unpaid paid days (worksheet S-2, line 24, column 2)	1,208	0			1,208	16.00
17.00	Out-of-State Medicaid paid days (worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (worksheet S-2, line 24, column 4)	40	0			40	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (worksheet S-2, line 24, column 5)	6,420	0			6,420	19.00
20.00	Other Medicaid days (worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	10,155	0			10,155	21.00
22.00	Total patient days (worksheet S-3, Part I, Column 8, Line 14)	24,971	0			24,971	22.00
23.00	Plus total labor room days (worksheet S-3, Part I, Column 8, Line 32)	69	0			69	23.00
24.00	Plus total employee discount days (worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	25,040	0			25,040	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	40.56	0.00			40.56	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet DSH Date/Time Prepared: 5/24/2017 9:20 am
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		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	30.08		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		30.08		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		30.08		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet DSH Date/Time Prepared: 5/24/2017 9:20 am
		Title XVIII	Hospital	PPS

		Revised Percentage 6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	22.68	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	22.68	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	22.68	31.00

Provider CCN: 14-0292

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

Worksheet E
 Part A Exhibit 4
 Date/Time Prepared:
 5/24/2017 9:20 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,594,753	0	7,594,753		7,594,753	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,604,305	0		2,604,305	2,604,305	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	94,324	0	53,107	41,217	94,324	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3008	0.3008	0.3008	0.3008		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	766,970	0	571,126	195,844	766,970	11.00
11.01	Uncompensated care payments	36.00	1,824,890	0	1,397,951	426,939	1,824,890	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,885,242	0	9,616,937	3,268,305	12,885,242	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,885,242	0	9,616,937	3,268,305	12,885,242	15.00
16.00	Payment for inpatient program capital	50.00	910,785	0	676,259	234,526	910,785	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

Provider CCN: 14-0292

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

Worksheet E
 Part A Exhibit 4
 Date/Time Prepared:
 5/24/2017 9:20 am

		Title XVIII			Hospital		PPS	
		w/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	10,293,196	3,502,831	13,796,027	19.00
		w/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	820,019	0	609,191	210,828	820,019	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,254	0	2,798	1,456	4,254	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1055	0.1055	0.1055	0.1055		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	86,512	0	64,270	22,242	86,512	25.00
26.00	Total prospective capital payments (see instructions)	12.00	910,785	0	676,259	234,526	910,785	26.00
		w/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to wkst. E, Pt. A.		Y					100.00

		Title XVIII			Hospital	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,594,753	7,594,753		7,594,753	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,604,305		2,604,305	2,604,305	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	94,324	53,107	41,217	94,324	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3008	0.3008	0.3008		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	766,970	571,126	195,844	766,970	11.00
11.01	Uncompensated care payments	36.00	1,824,890	1,397,951	426,939	1,824,890	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,885,242	9,616,937	3,268,305	12,885,242	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,885,242	9,616,937	3,268,305	12,885,242	15.00
16.00	Payment for inpatient program capital	50.00	910,785	676,259	234,526	910,785	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,293,196	3,502,831	13,796,027	19.00

		Title XVIII			Hospital		PPS
	wkst. L, line	(Amt. from wkst. L)					
	0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	820,019	609,191	210,828	820,019	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,254	2,798	1,456	4,254	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1055	0.1055	0.1055		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	86,512	64,270	22,242	86,512	25.00
26.00	Total prospective capital payments (see instructions)	12.00	910,785	676,259	234,526	910,785	26.00
	wkst. E, Pt. A, line	(Amt. from wkst. E, Pt. A)					
	0	1.00	2.00	3.00	4.00		
27.00		70.96	0	0		0	27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	6,130	10,088	-3,958	6,130	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-14,996	-3,798	-11,198	-14,996	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
					(Amt. to wkst. E, Pt. A)		
	0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/24/2017 9:20 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,378	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,092,675	2.00
3.00	PPS payments		2,893,858	3.00
4.00	Outlier payment (see instructions)		18,596	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,378	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		29,971	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)		29,971	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)		29,971	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		21,593	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)		8,378	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		2,912,454	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)		569,650	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,351,182	27.00
28.00	Direct graduate medical education payments (from wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,351,182	30.00
31.00	Primary payer payments		194	31.00
32.00	Subtotal (line 30 minus line 31)		2,350,988	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)		138,857	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		90,257	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		133,723	36.00
37.00	Subtotal (see instructions)		2,441,245	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,441,245	40.00
40.01	Sequestration adjustment (see instructions)		48,825	40.01
41.00	Interim payments		2,427,698	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-35,278	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2017 9:20 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		12,482,668		2,458,283	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	11/02/2016	74,014		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	11/02/2016	30,585	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)		74,014		-30,585	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		12,556,682		2,427,698	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		84,318		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		35,278	6.02	
7.00	Total Medicare program liability (see instructions)		12,641,000		2,392,420	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: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 5/24/2017 9:20 am	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		2,397,625		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,397,625		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		21,929		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,419,554		0
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
			0		
8.00	Name of Contractor				0

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0292

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

Worksheet E-1
Part II
Date/Time Prepared:
5/24/2017 9:20 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			5,078 1.00
2.00	Medicare days from wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			7,353 2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2			601 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			24,333 4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200			250,896,866 5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20			6,718,075 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 IPSS & 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
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/24/2017 9:20 am
	Title XVIII	Subprovider - IPF		PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,612,945	1.00
2.00	Net IPF PPS Outlier Payments		21,906	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		12.237705	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,634,851	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,634,851	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,634,851	18.00
19.00	Deductibles		166,068	19.00
20.00	Subtotal (line 18 minus line 19)		2,468,783	20.00
21.00	Coinsurance		22,218	21.00
22.00	Subtotal (line 20 minus line 21)		2,446,565	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		34,412	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		22,368	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,044	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,468,933	26.00
27.00	Direct graduate medical education payments (from wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,468,933	31.00
31.01	Sequestration adjustment (see instructions)		49,379	31.01
32.00	Interim payments		2,397,625	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		21,929	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part II, line 2		21,906	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0292

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

Worksheet G

Date/Time Prepared:

5/24/2017 9:20 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	-5,718,664	0	0	0	1.00
2.00	Temporary investments	1,945	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,772,300	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,728,609	0	0	0	6.00
7.00	Inventory	1,887,302	0	0	0	7.00
8.00	Prepaid expenses	30,513	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,244,787	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,869,112	0	0	0	12.00
13.00	Land improvements	486,536	0	0	0	13.00
14.00	Accumulated depreciation	-163,733	0	0	0	14.00
15.00	Buildings	35,895,339	0	0	0	15.00
16.00	Accumulated depreciation	-15,882,929	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	7,845,911	0	0	0	19.00
20.00	Accumulated depreciation	-6,913,729	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	17,630,397	0	0	0	23.00
24.00	Accumulated depreciation	-14,572,981	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)	26,193,923	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,573,705	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	645,042	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,218,747	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,657,457	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,700,372	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,706,945	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	737,817	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	5,602,268	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,747,402	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,086,922	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,444	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,109,366	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,856,768	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,800,689	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)	18,800,689	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,657,457	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0292

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

Worksheet G-1

Date/Time Prepared:
5/24/2017 9:20 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		24,839,538		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		265,004			2.00
3.00	Total (sum of line 1 and line 2)		25,104,542		0	3.00
4.00	DONOR RESTRICTED FUND BAL	157,096		0		4.00
5.00	ROUNDING	2,647		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)		159,743		0	10.00
11.00	Subtotal (line 3 plus line 10)		25,264,285		0	11.00
12.00	GENERAL FUND BALANCE	6,463,596		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)		6,463,596		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,800,689		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	DONOR RESTRICTED FUND BAL		0			4.00
5.00	ROUNDING		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	GENERAL FUND BALANCE		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: 14-0292

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2017 9:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	31,536,581		31,536,581	1.00
2.00	SUBPROVIDER - IPF	6,808,080		6,808,080	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,344,661		38,344,661	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,214,155		5,214,155	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,214,155		5,214,155	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	43,558,816		43,558,816	17.00
18.00	Ancillary services	77,938,088	89,423,434	167,361,522	18.00
19.00	Outpatient services	8,799,130	31,343,250	40,142,380	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHARMACY	0	562,085	562,085	27.00
27.01	PHYSICIAN REVENUE	0	467,292	467,292	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	130,296,034	121,796,061	252,092,095	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		89,490,292		29.00
30.00	BAD DEBT	4,598,982			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)		4,598,982		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)		94,089,274		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0292

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

Worksheet G-3

Date/Time Prepared:
5/24/2017 9:20 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	252,092,095	1.00
2.00	Less contractual allowances and discounts on patients' accounts	167,005,054	2.00
3.00	Net patient revenues (line 1 minus line 2)	85,087,041	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	94,089,274	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,002,233	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR REVENUE	9,267,237	24.00
25.00	Total other income (sum of lines 6-24)	9,267,237	25.00
26.00	Total (line 5 plus line 25)	265,004	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	265,004	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0292	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/24/2017 9:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		820,019	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,254	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)		66.67	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)		8.97	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		40.56	8.00
9.00	Sum of lines 7 and 8		49.53	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.55	10.00
11.00	Disproportionate share adjustment (see instructions)		86,512	11.00
12.00	Total prospective capital payments (see instructions)		910,785	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