

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: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 10:03 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2017 Time: 10:03 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
 Officer or Administrator of Provider(s)

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-407,499	-26,757	0	0	1.00
2.00 Subprovider - IPF	0	850	1,144		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-406,649	-25,613	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 8:54 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 7150 CLEARVISTA DRIVE			PO Box:							1.00
2.00	City: INDIANAPOLIS			State: IN		Zip Code: 46256		County: MARI ON			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		V		XVIII	XIX						
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		COMMUNITY HOSPITAL OF INDIANA, INC.	150169	26900	1	02/25/2008	N	P	P	3.00
4.00	Subprovider - IPF		COMMUNITY MENTAL HEALTH	15S169	26900	4	01/01/2010	N	P	O	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	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.			2,748	1,177	10	11	17,268	33		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0			25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 8:54 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	Y		40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		1.55	1.55			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	2.83	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY PRACTICE	1350	0.00	1.55	0.000000 67.00	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	76.00
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N			81.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N			86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N			87.00
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00

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		V		XIX				
		1.00		2.00				
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00		
Rural Providers								
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00		
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00		
					1.00	2.00	3.00	
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	1				118.00		
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	963,025		0		0		
					1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02		
119.00	DO NOT USE THIS LINE					119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00		
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00		
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 8:54 am	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				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: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101		141.00	
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095		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	N	161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 8:54 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)		01/01/2015	12/31/2015	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: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 8:54 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y					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	04/29/2014	Y	04/29/2014		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 8:54 am	
		Description		Y/N	Y/N		
		0		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N		20.00
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N		21.00
						1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions						22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions						24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.						25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.						26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						27.00
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions						29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.						30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.						31.00
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.						33.00
Provider-Based Physicians							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.						34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.						35.00
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?						36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.						37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.						38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.						39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.						40.00
						1.00	2.00
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD		HELMS			41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501		RHELMS@COMMUNITY.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0169

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

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2017 8:54 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 8:54 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	229	82,812	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)		229	82,812	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,784	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 NEONATAL INTENSIVE CARE UNIT	35.00	42	15,372	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		295	106,968	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	19	6,954		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)		314				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 8:54 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	19,005	2,098	53,157			1.00
2.00 HMO and other (see instructions)	7,159	15,756				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	19,005	2,098	53,157			7.00
8.00 INTENSIVE CARE UNIT	2,134	0	5,460			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 NEONATAL INTENSIVE CARE UNIT	0	46	11,195			12.00
13.00 NURSERY		3,314	7,426			13.00
14.00 Total (see instructions)	21,139	5,458	77,238	3.89	1,368.31	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,868	0	2,501	0.50	14.20	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	434			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)				4.39	1,382.51	27.00
28.00 Observation Bed Days		0	7,737			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2,122			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	33	1,142			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 8:54 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,590	195	16,256	1.00
2.00 HMO and other (see instructions)			1,422	2,517		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,590	195	16,256	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	193	0	272	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2017 8:54 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	89,078,230	-447,618	88,630,612	2,875,615.00	30.82
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		248,982	0	248,982	1,992.00	124.99
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		1,565,896	0	1,565,896	31,132.00	50.30
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,570,125	-5,910	1,564,215	51,159.00	30.58
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,400,456	0	1,400,456	14,189.00	98.70
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		3,970,567	0	3,970,567	28,545.00	139.10
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		25,510,628	0	25,510,628	660,633.00	38.62
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)		28,926,075	0	28,926,075		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		530,283	0	530,283		
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		24,548	0	24,548		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		368,353	0	368,353		
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		5,415,236	0	5,415,236		
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	178,153	0	178,153	4,838.00	36.82
27.00	Administrative & General	5.00	5,228,444	0	5,228,444	150,793.00	34.67

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2017 8:54 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		7,743,996	0	7,743,996	74,501.00	103.94	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,541,614	0	2,541,614	121,004.00	21.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,271,085	0	2,271,085	152,568.00	14.89	32.00
33.00	Housekeeping under contract (see instructions)		419,619	0	419,619	9,911.00	42.34	33.00
34.00	Dietary	10.00	2,158,367	-1,357,188	801,179	48,098.00	16.66	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,357,188	1,357,188	81,478.00	16.66	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,139,214	0	2,139,214	72,485.00	29.51	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	4,093,877	0	4,093,877	101,560.00	40.31	40.00
41.00	Medical Records & Medical Records Library	16.00	289,205	0	289,205	7,962.00	36.32	41.00
42.00	Social Service	17.00	2,037,373	0	2,037,373	58,816.00	34.64	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2017 8:54 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	95,675,949	-447,618	95,228,331	2,928,895.00	32.51	1.00
2.00	Excluded area salaries (see instructions)	1,570,125	-5,910	1,564,215	51,159.00	30.58	2.00
3.00	Subtotal salaries (line 1 minus line 2)	94,105,824	-441,708	93,664,116	2,877,736.00	32.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	30,881,651	0	30,881,651	703,367.00	43.91	4.00
5.00	Subtotal wage-related costs (see inst.)	34,365,859	0	34,365,859	0.00	36.69	5.00
6.00	Total (sum of lines 3 thru 5)	159,353,334	-441,708	158,911,626	3,581,103.00	44.38	6.00
7.00	Total overhead cost (see instructions)	29,100,947	0	29,100,947	884,014.00	32.92	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2017 8:54 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,483,940 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			7,085,007 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)			9,055,887 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			3,431,386 9.00
10.00	Dental, Hearing and Vision Plan			149,072 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			45,701 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)			766,979 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			172,739 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			6,564,561 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 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			93,985 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			29,849,257 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: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/30/2017 8:54 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	1,400,456	29,849,257	1.00
2.00	Hospital	1,400,456	29,318,975	2.00
3.00	Subprovider - IPF	0	306,121	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	224,161	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/30/2017 8:54 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.232563	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		31,977,041	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		224,820,174	6.00	
7.00	Medicaid cost (line 1 times line 6)		52,284,854	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)		20,307,813	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		20,307,813	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Charity care charges for the entire facility (see instructions)	808,004	1,226,634	2,034,638	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	187,912	285,270	473,182	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	187,912	285,270	473,182	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)		20,104,000	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		333,249	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		19,770,751	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		4,597,945	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,071,127	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		25,378,940	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	16,682,499	16,682,499	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	11,286,419	11,286,419	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	178,153	227,430	405,583	-98,368	307,215	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,228,444	109,973,694	115,202,138	-17,352,478	97,849,660	5.00
7.00	00700	OPERATION OF PLANT	2,541,614	6,820,040	9,361,654	-65,729	9,295,925	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	766,698	766,698	-86	766,612	8.00
9.00	00900	HOUSEKEEPING	2,271,085	1,516,321	3,787,406	-11,401	3,776,005	9.00
10.00	01000	DIETARY	2,158,367	1,014,841	3,173,208	-2,014,869	1,158,339	10.00
11.00	01100	CAFETERIA	0	0	0	1,962,212	1,962,212	11.00
13.00	01300	NURSING ADMINISTRATION	2,139,214	585,075	2,724,289	-10,002	2,714,287	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,037,249	1,037,249	-1,676,822	-639,573	14.00
15.00	01500	PHARMACY	4,093,877	13,774,040	17,867,917	-13,439,186	4,428,731	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289,205	186,620	475,825	-201	475,624	16.00
17.00	01700	SOCIAL SERVICE	2,037,373	802,106	2,839,479	-125	2,839,354	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,530,160	23,020,426	51,550,586	-11,340,789	40,209,797	30.00
31.00	03100	INTENSIVE CARE UNIT	3,619,159	1,664,453	5,283,612	-455,744	4,827,868	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,026,673	2,272,270	8,298,943	-214,942	8,084,001	35.00
40.00	04000	SUBPROVIDER - I PF	1,003,708	441,780	1,445,488	-20,494	1,424,994	40.00
43.00	04300	NURSERY	0	0	0	2,620,759	2,620,759	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,548,512	30,248,111	34,796,623	-22,283,881	12,512,742	50.00
51.00	05100	RECOVERY ROOM	1,974,851	1,068,164	3,043,015	-36,473	3,006,542	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	354,407	237,589	591,996	5,969,001	6,560,997	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,180,007	2,192,170	5,372,177	-1,118,915	4,253,262	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	364,237	2,326,338	2,690,575	-1,427,549	1,263,026	55.00
57.00	05700	CT SCAN	768,253	788,045	1,556,298	-347,301	1,208,997	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	437,936	2,004,959	2,442,895	-547,053	1,895,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9	9	-120,621	-120,612	59.00
60.00	06000	LABORATORY	208,903	9,090,685	9,299,588	-44,597	9,254,991	60.00
64.00	06400	INTRAVENOUS THERAPY	275,749	204,475	480,224	-13,744	466,480	64.00
65.00	06500	RESPIRATORY THERAPY	2,603,600	1,637,132	4,240,732	-386,530	3,854,202	65.00
66.00	06600	PHYSICAL THERAPY	4,744,860	2,254,685	6,999,545	-2,380,850	4,618,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,316,317	1,316,317	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	253,436	253,436	68.00
69.00	06900	ELECTROCARDIOLOGY	72,805	578,122	650,927	-12,839	638,088	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	912,227	619,801	1,532,028	-197,835	1,334,193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,422,228	12,422,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,524,803	11,524,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,836,233	13,836,233	73.00
74.00	07400	RENAL DIALYSIS	0	972,419	972,419	-3,552	968,867	74.00
76.00	03330	ENDOSCOPY	957,009	1,709,171	2,666,180	-965,854	1,700,326	76.00
76.06	03954	IMAGING CENTER	1,319,121	3,001,391	4,320,512	-985,381	3,335,131	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	4,773,969	4,773,969	-60,458	4,713,511	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPI NE CENTER	176,899	48,029	224,928	3,054	227,982	90.26
91.00	09100	EMERGENCY	5,495,405	3,212,190	8,707,595	-194,042	8,513,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,511,813	231,070,497	319,582,310	48,250	319,630,560	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	169,058	169,058	0	169,058	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	17,759	17,759	2,702	20,461	194.06
194.08	07958	OTHER NRCC	555,197	1,602,570	2,157,767	-50,952	2,106,815	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	11,220	889	12,109	0	12,109	194.10
200.00		TOTAL (SUM OF LINES 118-199)	89,078,230	232,860,773	321,939,003	0	321,939,003	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

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

Worksheet A
Date/Time Prepared:
5/30/2017 8:54 am

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	-3,197,447	13,485,052	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,143,138	14,429,557	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,869,214	4,176,429	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-40,130,495	57,719,165	5.00
7.00	00700	OPERATION OF PLANT	791,970	10,087,895	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	766,612	8.00
9.00	00900	HOUSEKEEPING	-8,754	3,767,251	9.00
10.00	01000	DIETARY	-19,671	1,138,668	10.00
11.00	01100	CAFETERIA	-68,248	1,893,964	11.00
13.00	01300	NURSING ADMINISTRATION	2,976,323	5,690,610	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,054,952	415,379	14.00
15.00	01500	PHARMACY	0	4,428,731	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,032,310	3,507,934	16.00
17.00	01700	SOCIAL SERVICE	0	2,839,354	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	331,366	331,366	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	579,259	579,259	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,211,551	41,421,348	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,827,868	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-217,902	7,866,099	35.00
40.00	04000	SUBPROVIDER - I PF	-4,000	1,420,994	40.00
43.00	04300	NURSERY	0	2,620,759	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-517,952	11,994,790	50.00
51.00	05100	RECOVERY ROOM	0	3,006,542	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,560,997	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	492,136	4,745,398	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,263,026	55.00
57.00	05700	CT SCAN	-588	1,208,409	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,895,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	83,578	-37,034	59.00
60.00	06000	LABORATORY	-1,296,418	7,958,573	60.00
64.00	06400	INTRAVENOUS THERAPY	0	466,480	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,854,202	65.00
66.00	06600	PHYSICAL THERAPY	-125	4,618,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,316,317	67.00
68.00	06800	SPEECH PATHOLOGY	0	253,436	68.00
69.00	06900	ELECTROCARDIOLOGY	31,221	669,309	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	272,233	1,606,426	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,422,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,524,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	983,268	14,819,501	73.00
74.00	07400	RENAL DIALYSIS	0	968,867	74.00
76.00	03330	ENDOSCOPY	0	1,700,326	76.00
76.06	03954	IMAGING CENTER	0	3,335,131	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	4,713,511	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.26	04975	SPINE CENTER	0	227,982	90.26
91.00	09100	EMERGENCY	-215,839	8,297,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-26,824,920	292,805,640	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	169,058	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	20,461	194.06
194.08	07958	OTHER NRCC	0	2,106,815	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	12,109	194.10
200.00		TOTAL (SUM OF LINES 118-199)	-26,824,920	295,114,083	200.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - Labor and Delivery Salary						
1.00	NURSERY	43.00	1,824,708	0	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,155,927	0	2.00	
	0		5,980,635	0		
B - Labor and Delivery Other						
1.00	NURSERY	43.00	0	796,051	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,813,074	2.00	
	TOTALS		0	2,609,125		
C - Chargeable Medical Supplies						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,422,228	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
	0		0	12,422,228		
D - Depreciation Expense						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,752,244	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
	0		0	12,752,244		
E - Radiology Support Salary						
1.00	RADIOLOGY-THERAPEUTIC	55.00	74,555		1.00	
2.00	CT SCAN	57.00	175,971		2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	48,860		3.00	
	0		299,386	0		
F - Radiology Support Other						
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	27,850	1.00	
2.00	CT SCAN	57.00	0	65,734	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	18,252	3.00	
	0		0	111,836		

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
G - Capital Insurance Costs						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	263,784	1.00	
	0		0	263,784		
H - Implantable Device Recl ass						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,524,803	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
	TOTALS		0	11,524,803		
I - Interest Expense						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,598,978	1.00	
	0		0	9,598,978		
J - Other Capital Rental Recl ass						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,353,912	1.00	
2.00	OPERATION OF PLANT	7.00	0	2,702	2.00	
3.00	SPI NE CENTER	90.26	0	3,054	3.00	
4.00	EMERGENCY	91.00	0	30,763	4.00	
5.00	PAVILLIONS	194.06	0	18,333	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
	0		0	5,408,764		
K - Depreciation by CC						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,819,737	1.00	
	0		0	6,819,737		
L - Cafeteria Salary						
1.00	CAFETERIA	11.00	1,357,188	0	1.00	
			1,357,188	0		
M - Cafeteria Recl ass						
1.00	CAFETERIA	11.00	0	605,024	1.00	
	0		0	605,024		
O - Drugs Charges to Pat						
1.00	LABORATORY	60.00	0	2,386	1.00	
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,836,233	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	

RECLASSIFICATIONS

Provider CCN: 15-0169

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

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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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	13,838,619	
R - Therapy Salary					
1.00	OCCUPATIONAL THERAPY	67.00	916,716	0	1.00
2.00	SPEECH PATHOLOGY	68.00	176,499	0	2.00
	TOTALS		1,093,215	0	
S - Therapy Other					
1.00	OCCUPATIONAL THERAPY	67.00		399,601	1.00
2.00	SPEECH PATHOLOGY	68.00		76,937	2.00
			0	476,538	
T - STD BENEFIT RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	5,092	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	67,054	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	14,487	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	11,837	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	5,844	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	16,688	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	48,133	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	464	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	34,945	9.00
10.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	70,780	10.00
11.00	SUBPROVIDER - IPF	40.00	0	5,910	11.00
12.00	OPERATING ROOM	50.00	0	9,568	12.00
13.00	OPERATING ROOM	50.00	0	28,073	13.00
14.00	RECOVERY ROOM	51.00	0	10,216	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,850	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,454	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,932	17.00
18.00	LABORATORY	60.00	0	3,606	18.00
19.00	INTRAVENOUS THERAPY	64.00	0	1,423	19.00
20.00	RESPIRATORY THERAPY	65.00	0	13,402	20.00
21.00	RESPIRATORY THERAPY	65.00	0	1,678	21.00
22.00	PHYSICAL THERAPY	66.00	0	2,299	22.00
23.00	PHYSICAL THERAPY	66.00	0	20,452	23.00
24.00	PHYSICAL THERAPY	66.00	0	3,574	24.00
25.00	ELECTROCARDIOLOGY	69.00	0	1,765	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	315	26.00
27.00	ENDOSCOPY	76.00	0	6,560	27.00
28.00	IMAGING CENTER	76.06	0	5,628	28.00
29.00	IMAGING CENTER	76.06	0	4,554	29.00
30.00	EMERGENCY	91.00	0	751	30.00
31.00	EMERGENCY	91.00	0	36,722	31.00
32.00	EMERGENCY	91.00	0	4,562	32.00
	TOTALS		0	447,618	
500.00	Grand Total : Increases		8,730,424	76,879,298	500.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - Labor and Delivery Salary							
1.00	ADULTS & PEDIATRICS	30.00	5,980,635	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		5,980,635	0			
B - Labor and Delivery Other							
1.00	ADULTS & PEDIATRICS	30.00	0	2,609,125	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	2,609,125			
C - Chargeable Medical Supplies							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	78,438	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,153,201	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	240,940	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	57,276	0		4.00
5.00	OPERATING ROOM	50.00	0	8,967,137	0		5.00
6.00	RECOVERY ROOM	51.00	0	76	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,559	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	726,290	0		8.00
9.00	CT SCAN	57.00	0	186,712	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	14,722	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	56,876	0		11.00
12.00	INTRAVENOUS THERAPY	64.00	0	5,319	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	116,393	0		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	5	0		14.00
15.00	ENDOSCOPY	76.00	0	673,395	0		15.00
16.00	IMAGING CENTER	76.06	0	52,747	0		16.00
17.00	BREAST DIAGNOSTIC CENTER	76.07	0	213	0		17.00
18.00	EMERGENCY	91.00	0	69,929	0		18.00
	0		0	12,422,228			
D - Depreciation Expense							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,737	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,294,635	0		2.00
3.00	OPERATION OF PLANT	7.00	0	68,431	0		3.00
4.00	HOUSEKEEPING	9.00	0	10,343	0		4.00
5.00	DIETARY	10.00	0	51,826	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	7,899	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	83,420	0		7.00
8.00	PHARMACY	15.00	0	102,990	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	28	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,305,900	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	181,136	0		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	144,268	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	15,098	0		13.00
14.00	OPERATING ROOM	50.00	0	722,069	0		14.00
15.00	RECOVERY ROOM	51.00	0	12,079	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	586,571	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	251,924	0		17.00
18.00	CT SCAN	57.00	0	258,818	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	512,517	0		19.00
20.00	LABORATORY	60.00	0	7,789	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	195,382	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	105,324	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	9,964	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	90,668	0		24.00
25.00	ENDOSCOPY	76.00	0	271,673	0		25.00
26.00	IMAGING CENTER	76.06	0	302,071	0		26.00
27.00	BREAST DIAGNOSTIC CENTER	76.07	0	59,731	0		27.00
28.00	EMERGENCY	91.00	0	79,338	0		28.00
29.00	PAVILLIONS	194.06	0	15,615	0		29.00
	0		0	12,752,244			
E - Radiology Support Salary							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	299,386				1.00
2.00							2.00
3.00			299,386	0			3.00
F - Radiology Support Other							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	111,836	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	111,836			

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
G - Capital Insurance Costs							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	263,784	14		1.00
	O		0	263,784			
H - Implantable Device Reclass							
1.00	ADULTS & PEDIATRICS	30.00	0	23,976	0		1.00
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	1,571	0		2.00
3.00	OPERATING ROOM	50.00	0	10,758,306	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	249	0		4.00
5.00	RADIOLOGY-THERAPEUTIC	55.00	0	533,830	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	69	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	63,745	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	7,679	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	41	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2,544	0		10.00
11.00	IMAGING CENTER	76.06	0	121,463	0		11.00
12.00	EMERGENCY	91.00	0	11,330	0		12.00
	TOTALS		0	11,524,803			
I - Interest Expense							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,598,978	11		1.00
	O		0	9,598,978			
J - Other Capital Rental Reclass							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	93,631	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	195,026	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	86	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,058	0		4.00
5.00	DIETARY	10.00	0	831	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,103	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,509,407	0		7.00
8.00	PHARMACY	15.00	0	484,796	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	173	0		9.00
10.00	SOCIAL SERVICE	17.00	0	125	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	14,666	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	712	0		12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	514	0		13.00
14.00	SUBPROVIDER - IPF	40.00	0	346	0		14.00
15.00	OPERATING ROOM	50.00	0	1,756,412	0		15.00
16.00	RECOVERY ROOM	51.00	0	346	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,595	0		17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	726	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	346	0		19.00
20.00	LABORATORY	60.00	0	39,194	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	0	173	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	66,054	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	701,158	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	106,685	0		24.00
25.00	ENDOSCOPY	76.00	0	1,273	0		25.00
26.00	IMAGING CENTER	76.06	0	383,624	0		26.00
27.00	OTHER NRCC	194.08	0	47,704	0		27.00
	O		0	5,408,764			
K - Depreciation by CC							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,819,737	9		1.00
	O		0	6,819,737			
L - Cafeteria Salary							
1.00	DIETARY	10.00	1,357,188				1.00
			1,357,188	0			
M - Cafeteria Reclass							
1.00	DIETARY	10.00	0	605,024	0		1.00
	O		0	605,024			
Q - Drugs Charges to Pat							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,557	0		2.00
3.00	PHARMACY	15.00	0	12,851,400	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	253,286	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	32,956	0		5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	11,313	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	5,050	0		7.00
8.00	OPERATING ROOM	50.00	0	79,957	0		8.00
9.00	RECOVERY ROOM	51.00	0	23,972	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,719	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	17,184	0		11.00
12.00	CT SCAN	57.00	0	143,476	0		12.00

RECLASSIFICATIONS

Provider CCN: 15-0169

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

Worksheet A-6
Date/Time Prepared:
5/30/2017 8:54 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	86,511	0	13.00
14.00	INTRAVENOUS THERAPY	64.00	0	573	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	8,660	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	2,071	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	2,875	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	477	0	18.00
19.00	RENAL DIALYSIS	74.00	0	3,552	0	19.00
20.00	ENDOSCOPY	76.00	0	19,513	0	20.00
21.00	IMAGING CENTER	76.06	0	125,476	0	21.00
22.00	BREAST DIAGNOSTIC CENTER	76.07	0	514	0	22.00
23.00	EMERGENCY	91.00	0	64,208	0	23.00
24.00	PAVILLIONS	194.06	0	16	0	24.00
25.00	OTHER NRCC	194.08	0	3,248	0	25.00
			0	13,838,619		
R - Therapy Salary						
1.00	PHYSICAL THERAPY	66.00	1,093,215	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		1,093,215	0		
S - Therapy Other						
1.00	PHYSICAL THERAPY	66.00		476,538		1.00
2.00				0		2.00
				476,538		
T - STD BENEFIT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	5,092	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	67,054	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	14,487	0	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	11,837	0	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	5,844	0	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	16,688	0	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	48,133	0	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	464	0	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	34,945	0	0	9.00
10.00	NEONATAL INTENSIVE CARE UNIT	35.00	70,780	0	0	10.00
11.00	SUBPROVIDER - IPF	40.00	5,910	0	0	11.00
12.00	OPERATING ROOM	50.00	9,568	0	0	12.00
13.00	OPERATING ROOM	50.00	28,073	0	0	13.00
14.00	RECOVERY ROOM	51.00	10,216	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	3,850	0	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	1,454	0	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	5,932	0	0	17.00
18.00	LABORATORY	60.00	3,606	0	0	18.00
19.00	INTRAVENOUS THERAPY	64.00	1,423	0	0	19.00
20.00	RESPIRATORY THERAPY	65.00	13,402	0	0	20.00
21.00	RESPIRATORY THERAPY	65.00	1,678	0	0	21.00
22.00	PHYSICAL THERAPY	66.00	2,299	0	0	22.00
23.00	PHYSICAL THERAPY	66.00	20,452	0	0	23.00
24.00	PHYSICAL THERAPY	66.00	3,574	0	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	1,765	0	0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	315	0	0	26.00
27.00	ENDOSCOPY	76.00	6,560	0	0	27.00
28.00	IMAGING CENTER	76.06	5,628	0	0	28.00
29.00	IMAGING CENTER	76.06	4,554	0	0	29.00
30.00	EMERGENCY	91.00	751	0	0	30.00
31.00	EMERGENCY	91.00	36,722	0	0	31.00
32.00	EMERGENCY	91.00	4,562	0	0	32.00
	TOTALS		447,618	0		
500.00	Grand Total : Decreases		9,178,042	76,431,680		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2017 8:54 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	2,705,851	0	0	0	1.00
2.00	Land Improvements	3,158,137	0	0	0	2.00
3.00	Buildings and Fixtures	289,284,636	0	0	832,089	3.00
4.00	Building Improvements	2,794,712	1,820,702	0	1,820,702	4.00
5.00	Fixed Equipment	3,118,039	0	0	0	5.00
6.00	Movable Equipment	95,025,378	815,598	0	815,598	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	396,086,753	2,636,300	0	2,636,300	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	396,086,753	2,636,300	0	2,636,300	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,705,851	0			1.00
2.00	Land Improvements	3,158,137	0			2.00
3.00	Buildings and Fixtures	288,452,547	0			3.00
4.00	Building Improvements	4,615,414	0			4.00
5.00	Fixed Equipment	3,118,039	0			5.00
6.00	Movable Equipment	95,466,578	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	397,516,566	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	397,516,566	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2017 8:54 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: 15-0169

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2017 8:54 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	295,237,485	0	295,237,485	0.750513	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98,143,417	0	98,143,417	0.249487	0	2.00
3.00	Total (sum of lines 1-2)	393,380,902	0	393,380,902	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	6,819,737	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,075,645	5,353,912	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,895,382	5,353,912	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	6,401,531	0	0	263,784	13,485,052	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	14,429,557	2.00
3.00	Total (sum of lines 1-2)	6,401,531	0	0	263,784	27,914,609	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

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

Worksheet A-8

Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-7,745		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-841,342				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	-3,149,076				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	UTILIZATION REVIEW - SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 Misc Revenue	B	-15,839		EMERGENCY	91.00	0	33.00
33.01 Misc Revenue	B	-133,086		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

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

Worksheet A-8

Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.02 Mi sc Revenue	B	-111,539	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 Mi sc Revenue	B	-35,375	OPERATION OF PLANT	7.00	0	33.03
33.04 Mi sc Revenue	B	-8,754	HOUSEKEEPING	9.00	0	33.04
33.05 Mi sc Revenue	B	-19,671	DIETARY	10.00	0	33.05
33.06 Mi sc Revenue	B	-52,610	NURSING ADMINISTRATION	13.00	0	33.06
33.07 Mi sc Revenue	B	-23,360	ADULTS & PEDIATRICS	30.00	0	33.07
33.08 Mi sc Revenue	B	-45	NEONATAL INTENSIVE CARE UNIT	35.00	0	33.08
33.09 Mi sc Revenue	B	-202	OPERATING ROOM	50.00	0	33.09
33.10 Mi sc Revenue	B	-113,402	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11 Mi sc Revenue	B	-1,296,418	LABORATORY	60.00	0	33.11
33.12 Mi sc Revenue	B	-125	PHYSICAL THERAPY	66.00	0	33.12
34.01 00 Non-Allow Interest Expense	A	-27,749	CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02 LOC Non-Allow Interest Expense	A	-69,400	CAP REL COSTS-BLDG & FIXT	1.00	11	34.02
34.03 12A Non-Allow Interest Expense	A	-2,550,274	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.04 12B Non-Allow Interest Expense	A	-139,657	CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05 50M BMO Non-Allow Interest Expense	A	-248,253	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06 Non-Allow Debt Issuance Expense	A	-81,276	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07 16AB Non-Allow Interest Expense	A	-162,114	CAP REL COSTS-BLDG & FIXT	1.00	11	34.07
35.00 HAF Tax Offset	A	-17,491,081	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 Meals of Wheels Cost	A	-68,248	CAFETERIA	11.00	0	36.00
36.01 Sponsorship	A	-44,000	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02 Nurse Practitioner Offset	A	-217,857	NEONATAL INTENSIVE CARE UNIT	35.00	0	36.02
36.03 Cardiac Cath Expense	A	83,578	CARDIAC CATHETERIZATION	59.00	0	36.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,824,920				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 15-0169
 Period: From 01/01/2016 To 12/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 5/30/2017 8:54 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	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	331,366	0 1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	579,259	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	7250 CLEARVISTA	212,960	192,934 3.00
3.01	70.00	ELECTROENCEPHALOGRAPHY	7250 CLEARVISTA	109,151	96,905 3.01
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	3,143,138	0 4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHNW - HOME OFFICE	4,002,300	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	41,483,898	63,779,774 4.02
4.03	7.00	OPERATION OF PLANT	CHNW - HOME OFFICE	827,345	0 4.03
4.04	13.00	NURSING ADMINISTRATION	CHNW - HOME OFFICE	3,028,933	0 4.04
4.05	14.00	CENTRAL SERVICES & SUPPLY	CHNW - HOME OFFICE	1,054,952	0 4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	CHNW - HOME OFFICE	3,032,310	0 4.06
4.07	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	1,234,911	0 4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	CHNW - HOME OFFICE	605,538	0 4.08
4.09	69.00	ELECTROCARDIOLOGY	CHNW - HOME OFFICE	31,221	0 4.09
4.10	70.00	ELECTROENCEPHALOGRAPHY	CHNW - HOME OFFICE	259,987	0 4.10
4.11	73.00	DRUGS CHARGED TO PATIENTS	CHNW - HOME OFFICE	983,268	0 4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			60,920,537	64,069,613 5.00

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

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

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

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

6.00	B	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	G			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: 15-0169

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2017 8:54 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	331,366	0		1.00
2.00	579,259	0		2.00
3.00	20,026	0		3.00
3.01	12,246	0		3.01
4.00	3,143,138	9		4.00
4.01	4,002,300	0		4.01
4.02	-22,295,876	0		4.02
4.03	827,345	0		4.03
4.04	3,028,933	0		4.04
4.05	1,054,952	0		4.05
4.06	3,032,310	0		4.06
4.07	1,234,911	0		4.07
4.08	605,538	0		4.08
4.09	31,221	0		4.09
4.10	259,987	0		4.10
4.11	983,268	0		4.11
5.00	-3,149,076			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0169

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2017 8:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	119,004	119,004	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	4,000	4,000	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	517,750	517,750	0	0	0	3.00
4.00	57.00	AGGREGATE-CT SCAN	588	588	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	200,000	200,000	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			841,342	841,342	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	57.00	AGGREGATE-CT SCAN	0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	119,004		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	4,000		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	517,750		3.00
4.00	57.00	AGGREGATE-CT SCAN	0	0	0	588		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	200,000		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	841,342		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	13,485,052	13,485,052			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	14,429,557		14,429,557		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,176,429	27,004	7,427	4,210,860	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	57,719,165	409,726	5,669,878	248,905	5.00
7.00 00700	OPERATION OF PLANT	10,087,895	2,023,054	137,956	120,996	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	766,612	46,665	0	0	8.00
9.00 00900	HOUSEKEEPING	3,767,251	108,396	16,216	108,117	9.00
10.00 01000	DIETARY	1,138,668	161,354	30,162	38,141	10.00
11.00 01100	CAFETERIA	1,893,964	273,335	51,093	64,610	11.00
13.00 01300	NURSING ADMINISTRATION	5,690,610	18,803	12,384	101,839	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	415,379	300,567	130,789	0	14.00
15.00 01500	PHARMACY	4,428,731	145,850	169,448	194,893	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,507,934	18,269	44	13,768	16.00
17.00 01700	SOCIAL SERVICE	2,839,354	21,321	0	96,991	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	331,366	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	579,259	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	41,421,348	3,973,659	1,786,688	1,065,415	30.00
31.00 03100	INTENSIVE CARE UNIT	4,827,868	881,525	283,992	170,630	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	7,866,099	795,289	226,189	283,536	35.00
40.00 04000	SUBPROVIDER - IPF	1,420,994	139,385	23,671	47,501	40.00
43.00 04300	NURSERY	2,620,759	437,721	79,557	86,867	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,994,790	600,352	1,192,385	214,745	50.00
51.00 05100	RECOVERY ROOM	3,006,542	331,270	18,938	93,528	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,560,997	996,938	181,199	214,719	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,745,398	198,179	883,207	136,600	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	1,263,026	200,944	404,051	20,889	55.00
57.00 05700	CT SCAN	1,208,409	26,584	427,205	44,951	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,895,842	111,523	809,494	23,174	58.00
59.00 05900	CARDIAC CATHETERIZATION	-37,034	19,642	0	0	59.00
60.00 06000	LABORATORY	7,958,573	115,471	12,212	9,773	60.00
64.00 06400	INTRAVENOUS THERAPY	466,480	141,731	0	13,060	64.00
65.00 06500	RESPIRATORY THERAPY	3,854,202	124,891	306,328	123,229	65.00
66.00 06600	PHYSICAL THERAPY	4,618,570	0	127,084	172,587	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,316,317	0	31,904	43,641	67.00
68.00 06800	SPEECH PATHOLOGY	253,436	0	6,143	8,402	68.00
69.00 06900	ELECTROCARDIOLOGY	669,309	0	15,622	3,382	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,606,426	30,608	142,153	43,412	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,422,228	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,524,803	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,819,501	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	968,867	2,384	0	0	74.00
76.00 03330	ENDOSCOPY	1,700,326	161,087	425,940	45,247	76.00
76.06 03954	IMAGING CENTER	3,335,131	0	469,385	62,313	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	4,713,511	0	93,649	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.26 04975	SPINE CENTER	227,982	0	4,788	8,421	90.26
91.00 09100	EMERGENCY	8,297,714	552,600	178,401	259,613	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW - SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	292,805,640	13,396,127	14,355,582	4,183,895	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,510	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	169,058	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	PAVILIONS	20,461	0	73,975	0	194.06
194.08 07958	OTHER NRCC	2,106,815	12,415	0	26,431	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	12,109	0	0	534	194.10
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	295,114,083	13,485,052	14,429,557	4,210,860	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	64,047,674				5.00
7.00	00700	OPERATION OF PLANT	3,428,467	15,798,368			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	225,409	66,867	1,105,553		8.00
9.00	00900	HOUSEKEEPING	1,108,642	155,323	0	5,263,945	9.00
10.00	01000	DIETARY	379,248	231,208	0	78,136	2,056,917
11.00	01100	CAFETERIA	632,761	391,668	0	132,364	0
13.00	01300	NURSING ADMINISTRATION	1,614,091	26,944	0	9,106	0
14.00	01400	CENTRAL SERVICES & SUPPLY	234,683	430,690	0	145,551	0
15.00	01500	PHARMACY	1,368,881	208,991	0	70,628	0
16.00	01600	MEDICAL RECORDS & LIBRARY	981,158	26,179	0	8,847	0
17.00	01700	SOCIAL SERVICE	819,753	30,551	0	10,325	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	91,842	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	160,549	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,372,289	5,693,951	569,402	1,924,262	1,371,218
31.00	03100	INTENSIVE CARE UNIT	1,708,431	1,263,158	73,975	426,882	140,844
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,541,884	1,139,588	32,145	385,122	288,782
40.00	04000	SUBPROVIDER - I/PF	452,204	199,728	0	67,498	64,515
43.00	04300	NURSERY	893,821	627,220	42,259	211,968	191,558
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,880,898	860,259	49,164	290,723	0
51.00	05100	RECOVERY ROOM	956,286	474,685	0	160,419	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,204,506	1,428,537	96,253	482,772	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,652,823	283,975	65,655	95,969	0
55.00	05500	RADIOLOGY-THERAPEUTIC	523,534	287,937	27,100	97,308	0
57.00	05700	CT SCAN	473,157	38,093	0	12,873	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	787,149	159,804	0	54,006	0
59.00	05900	CARDIAC CATHETERIZATION	0	28,146	0	9,512	0
60.00	06000	LABORATORY	2,243,912	165,461	0	55,917	0
64.00	06400	INTRAVENOUS THERAPY	172,193	203,089	0	68,634	0
65.00	06500	RESPIRATORY THERAPY	1,221,910	178,960	0	60,479	0
66.00	06600	PHYSICAL THERAPY	1,363,150	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	385,771	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	74,274	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	190,774	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	505,155	43,859	0	14,822	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,442,970	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,194,237	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,107,403	0	0	0	0
74.00	07400	RENAL DIALYSIS	269,194	3,416	0	1,154	0
76.00	03330	ENDOSCOPY	646,508	230,825	28,552	78,007	0
76.06	03954	IMAGING CENTER	1,071,738	0	0	0	0
76.07	03955	BREAST DIAGNOSTIC CENTER	1,332,362	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.26	04975	SPIRE CENTER	66,849	0	0	0	0
91.00	09100	EMERGENCY	2,574,372	791,834	121,048	267,599	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,355,238	15,670,946	1,105,553	5,220,883	2,056,917
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,206	109,633	0	37,050	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	46,856	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	PAVILLIONS	26,174	0	0	0	0
194.08	07958	OTHER NRCC	594,696	17,789	0	6,012	0
194.10	07960	COMMUNITY REHAB HOSPITAL	3,504	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	64,047,674	15,798,368	1,105,553	5,263,945	2,056,917

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,439,795					11.00
13.00	01300	114,988	7,588,765				13.00
14.00	01400	0	0	1,657,659			14.00
15.00	01500	160,984	0	3,745	6,752,151		15.00
16.00	01600	13,142	0	24	0	4,569,365	16.00
17.00	01700	91,991	0	126	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,140,027	3,563,330	54,581	0	518,844	30.00
31.00	03100	174,125	544,255	8,973	0	73,435	31.00
35.00	02060	266,116	831,786	8,300	0	282,364	35.00
40.00	04000	45,995	143,766	3,206	0	18,473	40.00
43.00	04300	88,705	277,262	4,121	0	36,772	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	220,121	688,021	98,988	0	566,588	50.00
51.00	05100	88,705	0	6,018	0	107,693	51.00
52.00	05200	203,694	636,676	9,386	0	78,576	52.00
54.00	05400	131,415	0	4,747	0	137,064	54.00
55.00	05500	19,712	0	9,110	0	87,745	55.00
57.00	05700	45,995	0	380	0	241,742	57.00
58.00	05800	22,998	0	2,188	0	82,061	58.00
59.00	05900	0	0	0	0	4,215	59.00
60.00	06000	6,571	0	90,345	0	386,980	60.00
64.00	06400	13,142	0	205	0	5,097	64.00
65.00	06500	128,130	0	4,188	0	100,563	65.00
66.00	06600	32,854	0	4,185	0	94,891	66.00
67.00	06700	39,425	0	1,049	0	25,345	67.00
68.00	06800	6,571	0	202	6,752,151	7,427	68.00
69.00	06900	3,285	0	20	0	29,150	69.00
70.00	07000	45,995	0	2,955	0	43,738	70.00
71.00	07100	0	0	806,599	0	290,797	71.00
72.00	07200	0	0	494,750	0	146,726	72.00
73.00	07300	0	0	0	6,752,151	362,714	73.00
74.00	07400	0	0	142	0	10,698	74.00
76.00	03330	45,995	0	6,413	0	67,769	76.00
76.06	03954	0	0	6,210	0	199,507	76.06
76.07	03955	0	0	253	0	40,469	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.26	04975	0	0	84	0	2,783	90.26
91.00	09100	289,114	903,669	22,200	0	519,139	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00	11800	3,439,795	7,588,765	1,653,693	6,752,151	4,569,365	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	3,432	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	216	0	0	194.06
194.08	07958	0	0	318	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,439,795	7,588,765	1,657,659	6,752,151	4,569,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	3,910,412					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0				19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0		423,208			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0			739,808		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2,606,828	0	122,431	214,022	79,398,295	30.00
31.00 03100 INTENSIVE CARE UNIT	267,759	0	0	0	10,845,852	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	549,004	0	0	0	15,496,204	35.00
40.00 04000 SUBPROVIDER - IPF	122,649	0	48,201	84,261	2,882,047	40.00
43.00 04300 NURSERY	364,172	0	0	0	5,962,762	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	20,657,034	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	5,244,084	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	13,094,253	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	8,335,032	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	2,941,356	55.00
57.00 05700 CT SCAN	0	0	0	0	2,519,389	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	3,948,239	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	24,481	59.00
60.00 06000 LABORATORY	0	0	0	0	11,045,215	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	1,083,631	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	6,102,880	65.00
66.00 06600 PHYSICAL THERAPY	0	0	5,784	10,111	6,429,216	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	1,843,452	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	356,455	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	911,542	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	2,479,123	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,962,594	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,360,516	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	26,041,769	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	1,255,855	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	3,436,669	76.00
76.06 03954 IMAGING CENTER	0	0	0	0	5,144,284	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	6,180,244	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.26 04975 SPINE CENTER	0	0	0	0	310,907	90.26
91.00 09100 EMERGENCY	0	0	16,388	28,649	14,822,340	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,910,412	0	192,804	337,043	291,115,720	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	244,399	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	230,404	402,765	852,515	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00
194.06 07956 PAVILLIONS	0	0	0	0	120,826	194.06
194.08 07958 OTHER NRCC	0	0	0	0	2,764,476	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	16,147	194.10
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	3,910,412	0	423,208	739,808	295,114,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-336,453	79,061,842
31.00	03100	INTENSIVE CARE UNIT	0	10,845,852
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	15,496,204
40.00	04000	SUBPROVIDER - I PF	-132,462	2,749,585
43.00	04300	NURSERY	0	5,962,762
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	20,657,034
51.00	05100	RECOVERY ROOM	0	5,244,084
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,094,253
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,335,032
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,941,356
57.00	05700	CT SCAN	0	2,519,389
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,948,239
59.00	05900	CARDIAC CATHETERIZATION	0	24,481
60.00	06000	LABORATORY	0	11,045,215
64.00	06400	INTRAVENOUS THERAPY	0	1,083,631
65.00	06500	RESPIRATORY THERAPY	0	6,102,880
66.00	06600	PHYSICAL THERAPY	-15,895	6,413,321
67.00	06700	OCCUPATIONAL THERAPY	0	1,843,452
68.00	06800	SPEECH PATHOLOGY	0	356,455
69.00	06900	ELECTROCARDIOLOGY	0	911,542
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,479,123
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,962,594
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,360,516
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,041,769
74.00	07400	RENAL DIALYSIS	0	1,255,855
76.00	03330	ENDOSCOPY	0	3,436,669
76.06	03954	IMAGING CENTER	0	5,144,284
76.07	03955	BREAST DIAGNOSTIC CENTER	0	6,180,244
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0
90.26	04975	SPINE CENTER	0	310,907
91.00	09100	EMERGENCY	-45,037	14,777,303
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW - SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-529,847	290,585,873
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	244,399
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-633,169	219,346
193.00	19300	NONPAID WORKERS	0	0
194.00	07950	HOME OFFICE	0	0
194.06	07956	PAVILLIONS	0	120,826
194.08	07958	OTHER NRCC	0	2,764,476
194.10	07960	COMMUNITY REHAB HOSPITAL	0	16,147
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	-1,163,016	293,951,067

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	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	27,004	7,427	34,431	34,431 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	409,726	5,669,878	6,079,604	2,034 5.00
7.00 00700	OPERATION OF PLANT	0	2,023,054	137,956	2,161,010	989 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	46,665	0	46,665	0 8.00
9.00 00900	HOUSEKEEPING	0	108,396	16,216	124,612	883 9.00
10.00 01000	DIETARY	0	161,354	30,162	191,516	312 10.00
11.00 01100	CAFETERIA	0	273,335	51,093	324,428	528 11.00
13.00 01300	NURSING ADMINISTRATION	0	18,803	12,384	31,187	832 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	300,567	130,789	431,356	0 14.00
15.00 01500	PHARMACY	0	145,850	169,448	315,298	1,593 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,269	44	18,313	113 16.00
17.00 01700	SOCIAL SERVICE	0	21,321	0	21,321	793 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	3,973,659	1,786,688	5,760,347	8,726 30.00
31.00 03100	INTENSIVE CARE UNIT	0	881,525	283,992	1,165,517	1,394 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	795,289	226,189	1,021,478	2,317 35.00
40.00 04000	SUBPROVIDER - I PF	0	139,385	23,671	163,056	388 40.00
43.00 04300	NURSERY	0	437,721	79,557	517,278	710 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	600,352	1,192,385	1,792,737	1,755 50.00
51.00 05100	RECOVERY ROOM	0	331,270	18,938	350,208	764 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	996,938	181,199	1,178,137	1,755 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	198,179	883,207	1,081,386	1,116 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	200,944	404,051	604,995	171 55.00
57.00 05700	CT SCAN	0	26,584	427,205	453,789	367 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	111,523	809,494	921,017	189 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	19,642	0	19,642	0 59.00
60.00 06000	LABORATORY	0	115,471	12,212	127,683	80 60.00
64.00 06400	INTRAVENOUS THERAPY	0	141,731	0	141,731	107 64.00
65.00 06500	RESPIRATORY THERAPY	0	124,891	306,328	431,219	1,007 65.00
66.00 06600	PHYSICAL THERAPY	0	0	127,084	127,084	1,410 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	31,904	31,904	357 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	6,143	6,143	69 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	15,622	15,622	28 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	30,608	142,153	172,761	355 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	2,384	0	2,384	0 74.00
76.00 03330	ENDOSCOPY	0	161,087	425,940	587,027	370 76.00
76.06 03954	IMAGING CENTER	0	0	469,385	469,385	509 76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	93,649	93,649	0 76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.26 04975	SPINE CENTER	0	0	4,788	4,788	69 90.26
91.00 09100	EMERGENCY	0	552,600	178,401	731,001	2,121 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	13,396,127	14,355,582	27,751,709	34,211 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,510	0	76,510	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	HOME OFFICE	0	0	0	0	0 194.00
194.06 07956	PAVILIONS	0	0	73,975	73,975	0 194.06
194.08 07958	OTHER NRCC	0	12,415	0	12,415	216 194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	4 194.10
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	0	13,485,052	14,429,557	27,914,609	34,431 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,081,638					5.00
7.00	00700	OPERATION OF PLANT	325,551	2,487,550				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,404	10,529	78,598			8.00
9.00	00900	HOUSEKEEPING	105,271	24,457	0	255,223		9.00
10.00	01000	DIETARY	36,012	36,405	0	3,788	268,033	10.00
11.00	01100	CAFETERIA	60,084	61,670	0	6,418	0	11.00
13.00	01300	NURSING ADMINISTRATION	153,266	4,242	0	441	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,284	67,815	0	7,057	0	14.00
15.00	01500	PHARMACY	129,983	32,907	0	3,424	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,166	4,122	0	429	0	16.00
17.00	01700	SOCIAL SERVICE	77,840	4,810	0	501	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	8,721	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,245	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,269,742	896,548	40,481	93,300	178,680	30.00
31.00	03100	INTENSIVE CARE UNIT	162,225	198,892	5,259	20,697	18,353	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	241,365	179,435	2,285	18,673	37,631	35.00
40.00	04000	SUBPROVIDER - I PF	42,939	31,448	0	3,273	8,407	40.00
43.00	04300	NURSERY	84,873	98,760	3,004	10,277	24,962	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	368,512	135,453	3,495	14,096	0	50.00
51.00	05100	RECOVERY ROOM	90,804	74,742	0	7,778	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,330	224,932	6,843	23,407	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,944	44,714	4,668	4,653	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	49,712	45,337	1,927	4,718	0	55.00
57.00	05700	CT SCAN	44,929	5,998	0	624	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	74,744	25,162	0	2,618	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,432	0	461	0	59.00
60.00	06000	LABORATORY	213,071	26,053	0	2,711	0	60.00
64.00	06400	INTRAVENOUS THERAPY	16,351	31,978	0	3,328	0	64.00
65.00	06500	RESPIRATORY THERAPY	116,027	28,178	0	2,932	0	65.00
66.00	06600	PHYSICAL THERAPY	129,438	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,631	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,053	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,115	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,967	6,906	0	719	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	326,928	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	303,310	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,020	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	25,561	538	0	56	0	74.00
76.00	03330	ENDOSCOPY	61,389	36,345	2,030	3,782	0	76.00
76.06	03954	IMAGING CENTER	101,767	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	126,515	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPINE CENTER	6,348	0	0	0	0	90.26
91.00	09100	EMERGENCY	244,450	124,679	8,606	12,975	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,015,887	2,467,487	78,598	253,136	268,033	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,014	17,262	0	1,796	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,449	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	2,485	0	0	0	0	194.06
194.08	07958	OTHER NRCC	56,470	2,801	0	291	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	333	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,081,638	2,487,550	78,598	255,223	268,033	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	453,128					11.00
13.00	01300	15,148	205,116				13.00
14.00	01400	0	0	528,512			14.00
15.00	01500	21,207	0	1,194	505,606		15.00
16.00	01600	1,731	0	8	0	117,882	16.00
17.00	01700	12,118	0	40	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	150,175	96,313	17,402	0	13,336	30.00
31.00	03100	22,938	14,711	2,861	0	1,888	31.00
35.00	02060	35,056	22,482	2,646	0	7,258	35.00
40.00	04000	6,059	3,886	1,022	0	475	40.00
43.00	04300	11,685	7,494	1,314	0	945	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	28,997	18,596	31,560	0	14,996	50.00
51.00	05100	11,685	0	1,919	0	2,768	51.00
52.00	05200	26,833	17,209	2,993	0	2,020	52.00
54.00	05400	17,311	0	1,513	0	3,523	54.00
55.00	05500	2,597	0	2,905	0	2,255	55.00
57.00	05700	6,059	0	121	0	6,214	57.00
58.00	05800	3,030	0	698	0	2,109	58.00
59.00	05900	0	0	0	0	108	59.00
60.00	06000	866	0	28,804	0	9,947	60.00
64.00	06400	1,731	0	65	0	131	64.00
65.00	06500	16,879	0	1,335	0	2,585	65.00
66.00	06600	4,328	0	1,334	0	2,439	66.00
67.00	06700	5,193	0	335	0	651	67.00
68.00	06800	866	0	64	0	191	68.00
69.00	06900	433	0	6	0	749	69.00
70.00	07000	6,059	0	942	0	1,124	70.00
71.00	07100	0	0	257,173	0	7,475	71.00
72.00	07200	0	0	157,738	0	3,771	72.00
73.00	07300	0	0	0	505,606	9,323	73.00
74.00	07400	0	0	45	0	275	74.00
76.00	03330	6,059	0	2,044	0	1,742	76.00
76.06	03954	0	0	1,980	0	5,128	76.06
76.07	03955	0	0	81	0	1,040	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.26	04975	0	0	27	0	72	90.26
91.00	09100	38,085	24,425	7,078	0	13,344	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00	11800	453,128	205,116	527,247	505,606	117,882	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	1,094	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	69	0	0	194.06
194.08	07958	0	0	102	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		453,128	205,116	528,512	505,606	117,882	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	117,423				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		8,721		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			15,245	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	78,279			8,603,329	30.00
31.00 03100	INTENSIVE CARE UNIT	8,040			1,622,775	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	16,486			1,587,112	35.00
40.00 04000	SUBPROVIDER - IPF	3,683			264,636	40.00
43.00 04300	NURSERY	10,935			772,237	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0			2,410,197	50.00
51.00 05100	RECOVERY ROOM	0			540,668	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0			1,693,459	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0			1,315,828	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0			714,617	55.00
57.00 05700	CT SCAN	0			518,101	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0			1,029,567	58.00
59.00 05900	CARDIAC CATHETERIZATION	0			24,643	59.00
60.00 06000	LABORATORY	0			409,215	60.00
64.00 06400	INTRAVENOUS THERAPY	0			195,422	64.00
65.00 06500	RESPIRATORY THERAPY	0			600,162	65.00
66.00 06600	PHYSICAL THERAPY	0			266,033	66.00
67.00 06700	OCCUPATIONAL THERAPY	0			75,071	67.00
68.00 06800	SPEECH PATHOLOGY	0			14,386	68.00
69.00 06900	ELECTROCARDIOLOGY	0			34,953	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0			236,833	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			591,576	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0			464,819	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0			904,949	73.00
74.00 07400	RENAL DIALYSIS	0			28,859	74.00
76.00 03330	ENDOSCOPY	0			700,788	76.00
76.06 03954	IMAGING CENTER	0			578,769	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0			221,285	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0			0	90.00
90.26 04975	SPINE CENTER	0			11,304	90.26
91.00 09100	EMERGENCY	0			1,206,764	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	117,423	0	0	0	27,638,357
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			97,582	190.00
191.00 19100	RESEARCH	0			0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0			5,543	192.00
193.00 19300	NONPAID WORKERS	0			0	193.00
194.00 07950	HOME OFFICE	0			0	194.00
194.06 07956	PAVILLIONS	0			76,529	194.06
194.08 07958	OTHER NRCC	0			72,295	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0			337	194.10
200.00	Cross Foot Adjustments		0	8,721	15,245	23,966
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	117,423	0	8,721	15,245	27,914,609

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 8:54 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	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
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	8,603,329		30.00
31.00 03100	INTENSIVE CARE UNIT	0	1,622,775		31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	1,587,112		35.00
40.00 04000	SUBPROVIDER - I/PF	0	264,636		40.00
43.00 04300	NURSERY	0	772,237		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	2,410,197		50.00
51.00 05100	RECOVERY ROOM	0	540,668		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	1,693,459		52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,315,828		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	714,617		55.00
57.00 05700	CT SCAN	0	518,101		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,029,567		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	24,643		59.00
60.00 06000	LABORATORY	0	409,215		60.00
64.00 06400	INTRAVENOUS THERAPY	0	195,422		64.00
65.00 06500	RESPIRATORY THERAPY	0	600,162		65.00
66.00 06600	PHYSICAL THERAPY	0	266,033		66.00
67.00 06700	OCCUPATIONAL THERAPY	0	75,071		67.00
68.00 06800	SPEECH PATHOLOGY	0	14,386		68.00
69.00 06900	ELECTROCARDIOLOGY	0	34,953		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	236,833		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	591,576		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	464,819		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	904,949		73.00
74.00 07400	RENAL DIALYSIS	0	28,859		74.00
76.00 03330	ENDOSCOPY	0	700,788		76.00
76.06 03954	IMAGING CENTER	0	578,769		76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	221,285		76.07
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0		90.00
90.26 04975	SPINE CENTER	0	11,304		90.26
91.00 09100	EMERGENCY	0	1,206,764		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW - SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	27,638,357		118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97,582		190.00
191.00 19100	RESEARCH	0	0		191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	5,543		192.00
193.00 19300	NONPAID WORKERS	0	0		193.00
194.00 07950	HOME OFFICE	0	0		194.00
194.06 07956	PAVILLIONS	0	76,529		194.06
194.08 07958	OTHER NRCC	0	72,295		194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	337		194.10
200.00	Cross Foot Adjustments	0	23,966		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	27,914,609		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	707,123				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		9,203,459			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,416	4,737	88,452,459		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,485	3,616,361	5,228,444	-64,047,674	5.00
7.00 00700	OPERATION OF PLANT	106,084	87,991	2,541,614	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,447	0	0	0	8.00
9.00 00900	HOUSEKEEPING	5,684	10,343	2,271,085	0	9.00
10.00 01000	DIETARY	8,461	19,238	801,179	0	10.00
11.00 01100	CAFETERIA	14,333	32,588	1,357,188	0	11.00
13.00 01300	NURSING ADMINISTRATION	986	7,899	2,139,214	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,761	83,420	0	0	14.00
15.00 01500	PHARMACY	7,648	108,077	4,093,877	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	958	28	289,205	0	16.00
17.00 01700	SOCIAL SERVICE	1,118	0	2,037,373	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	208,369	1,139,585	22,379,926	0	30.00
31.00 03100	INTENSIVE CARE UNIT	46,225	181,136	3,584,214	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	41,703	144,268	5,955,893	0	35.00
40.00 04000	SUBPROVIDER - IPF	7,309	15,098	997,798	0	40.00
43.00 04300	NURSERY	22,953	50,743	1,824,708	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,481	760,527	4,510,871	0	50.00
51.00 05100	RECOVERY ROOM	17,371	12,079	1,964,635	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	52,277	115,572	4,510,334	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,392	563,327	2,869,385	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	10,537	257,712	438,792	0	55.00
57.00 05700	CT SCAN	1,394	272,480	944,224	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	5,848	516,311	486,796	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,030	0	0	17,392	59.00
60.00 06000	LABORATORY	6,055	7,789	205,297	0	60.00
64.00 06400	INTRAVENOUS THERAPY	7,432	0	274,326	0	64.00
65.00 06500	RESPIRATORY THERAPY	6,549	195,382	2,588,520	0	65.00
66.00 06600	PHYSICAL THERAPY	0	81,057	3,625,320	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	20,349	916,716	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	3,918	176,499	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	9,964	71,040	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,605	90,668	911,912	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	125	0	0	0	74.00
76.00 03330	ENDOSCOPY	8,447	271,673	950,449	0	76.00
76.06 03954	IMAGING CENTER	0	299,383	1,308,939	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	59,731	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.26 04975	SPINE CENTER	0	3,054	176,899	0	90.26
91.00 09100	EMERGENCY	28,977	113,788	5,453,370	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW - SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	702,460	9,156,276	87,886,042	-64,030,282	228,585,493
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,012	0	0	0	76,510
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	169,058
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	PAVILLIONS	0	47,183	0	0	94,436
194.08 07958	OTHER NRCC	651	0	555,197	0	2,145,661
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	11,220	0	12,643
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					4.00
202.00	Cost to be allocated (per Wkst. B, Part I)	13,485,052	14,429,557	4,210,860		64,047,674	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19.070306	1.567841	0.047606		0.277162	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			34,431		6,081,638	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000389		0.026318	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	578,138				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,447	268,023			8.00
9.00	00900	HOUSEKEEPING	5,684	0	570,007		9.00
10.00	01000	DIETARY	8,461	0	8,461	79,739	10.00
11.00	01100	CAFETERIA	14,333	0	14,333	0	1,047
13.00	01300	NURSING ADMINISTRATION	986	0	986	0	35
14.00	01400	CENTRAL SERVICES & SUPPLY	15,761	0	15,761	0	0
15.00	01500	PHARMACY	7,648	0	7,648	0	49
16.00	01600	MEDICAL RECORDS & LIBRARY	958	0	958	0	4
17.00	01700	SOCIAL SERVICE	1,118	0	1,118	0	28
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	208,369	138,042	208,369	53,157	347
31.00	03100	INTENSIVE CARE UNIT	46,225	17,934	46,225	5,460	53
35.00	02060	NEONATAL INTENSIVE CARE UNIT	41,703	7,793	41,703	11,195	81
40.00	04000	SUBPROVIDER - IPF	7,309	0	7,309	2,501	14
43.00	04300	NURSERY	22,953	10,245	22,953	7,426	27
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,481	11,919	31,481	0	67
51.00	05100	RECOVERY ROOM	17,371	0	17,371	0	27
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,277	23,335	52,277	0	62
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,392	15,917	10,392	0	40
55.00	05500	RADIOLOGY-THERAPEUTIC	10,537	6,570	10,537	0	6
57.00	05700	CT SCAN	1,394	0	1,394	0	14
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,848	0	5,848	0	7
59.00	05900	CARDIAC CATHETERIZATION	1,030	0	1,030	0	0
60.00	06000	LABORATORY	6,055	0	6,055	0	2
64.00	06400	INTRAVENOUS THERAPY	7,432	0	7,432	0	4
65.00	06500	RESPIRATORY THERAPY	6,549	0	6,549	0	39
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1
70.00	07000	ELECTROENCEPHALOGRAPHY	1,605	0	1,605	0	14
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	125	0	125	0	0
76.00	03330	ENDOSCOPY	8,447	6,922	8,447	0	14
76.06	03954	IMAGING CENTER	0	0	0	0	0
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.26	04975	SPINE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	28,977	29,346	28,977	0	88
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW - SNF					
118.00		SUBTOTALS (SUM OF LINES 1-117)	573,475	268,023	565,344	79,739	1,047
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,012	0	4,012	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	PAVILLIONS	0	0	0	0	0
194.08	07958	OTHER NRCC	651	0	651	0	0
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	15,798,368	1,105,553	5,263,945	2,056,917	3,439,795
203.00		Unit cost multiplier (Wkst. B, Part I)	27.326292	4.124844	9.234878	25.795621	3,285.382044

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0169			Period: From 01/01/2016 To 12/31/2016		Worksheet B-1 Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)		
		7.00	8.00	9.00	10.00	11.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	2,487,550	78,598	255,223	268,033	453,128	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	4.302692	0.293251	0.447754	3.361379	432.787011	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	739					13.00
14.00	01400	0	39,279,059				14.00
15.00	01500	0	88,740	13,836,234			15.00
16.00	01600	0	562	0	1,249,494,496		16.00
17.00	01700	0	2,991	0	0	79,739	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	347	1,293,336	0	141,876,816	53,157	30.00
31.00	03100	53	212,610	0	20,080,585	5,460	31.00
35.00	02060	81	196,672	0	77,211,825	11,195	35.00
40.00	04000	14	75,978	0	5,051,443	2,501	40.00
43.00	04300	27	97,653	0	10,055,218	7,426	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	67	2,345,570	0	154,942,430	0	50.00
51.00	05100	0	142,599	0	29,448,429	0	51.00
52.00	05200	62	222,414	0	21,486,482	0	52.00
54.00	05400	0	112,479	0	37,480,031	0	54.00
55.00	05500	0	215,872	0	23,993,734	0	55.00
57.00	05700	0	9,005	0	66,104,005	0	57.00
58.00	05800	0	51,846	0	22,439,431	0	58.00
59.00	05900	0	0	0	1,152,710	0	59.00
60.00	06000	0	2,140,764	0	105,819,013	0	60.00
64.00	06400	0	4,856	0	1,393,708	0	64.00
65.00	06500	0	99,239	0	27,498,815	0	65.00
66.00	06600	0	99,167	0	25,947,880	0	66.00
67.00	06700	0	24,862	0	6,930,547	0	67.00
68.00	06800	0	4,787	0	2,030,866	0	68.00
69.00	06900	0	471	0	7,971,107	0	69.00
70.00	07000	0	70,019	0	11,959,981	0	70.00
71.00	07100	0	19,112,742	0	79,517,803	0	71.00
72.00	07200	0	11,723,378	0	40,121,910	0	72.00
73.00	07300	0	0	13,836,234	99,183,468	0	73.00
74.00	07400	0	3,360	0	2,925,252	0	74.00
76.00	03330	0	151,949	0	18,531,370	0	76.00
76.06	03954	0	147,138	0	54,554,929	0	76.06
76.07	03955	0	5,997	0	11,066,146	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.26	04975	0	1,979	0	760,924	0	90.26
91.00	09100	88	526,036	0	141,957,638	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		739	39,185,071	13,836,234	1,249,494,496	79,739	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	81,330	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	5,113	0	0	0	194.06
194.08	07958	0	7,545	0	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00
201.00							201.00
202.00		7,588,765	1,657,659	6,752,151	4,569,365	3,910,412	202.00
203.00		10,268.964817	0.042202	0.488005	0.003657	49.040143	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		(DIRECT NURS. HRS.)	(COSTED REQUIS.)				
204.00		13.00	14.00	15.00	16.00	17.00	
	Cost to be allocated (per Wkst. B, Part II)	205,116	528,512	505,606	117,882	117,423	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	277.558863	0.013455	0.036542	0.000094	1.472592	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description	INTERNS & RESIDENTS				
	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
	19.00	21.00	22.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD		439		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			439	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	127	127	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	35.00
40.00 04000	SUBPROVIDER - I PF	0	50	50	40.00
43.00 04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	6	6	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	76.00
76.06 03954	IMAGING CENTER	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.26 04975	SPINE CENTER	0	0	0	90.26
91.00 09100	EMERGENCY	0	17	17	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW - SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	200	200	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	239	239	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00
194.06 07956	PAVILLIONS	0	0	0	194.06
194.08 07958	OTHER NRCC	0	0	0	194.08
194.10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	194.10
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	423,208	739,808	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME) 19.00	INTERNS & RESIDENTS		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME) 21.00	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME) 22.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	964.027335	1,685.211845	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	8,721	15,245	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	19.865604	34.726651	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2017 8:54 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	79,061,842	79,061,842	0	79,061,842	30.00
31.00	03100 INTENSIVE CARE UNIT	10,845,852	10,845,852	0	10,845,852	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	15,496,204	15,496,204	0	15,496,204	35.00
40.00	04000 SUBPROVIDER - IPF	2,749,585	2,749,585	0	2,749,585	40.00
43.00	04300 NURSERY	5,962,762	5,962,762	0	5,962,762	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20,657,034	20,657,034	0	20,657,034	50.00
51.00	05100 RECOVERY ROOM	5,244,084	5,244,084	0	5,244,084	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,094,253	13,094,253	0	13,094,253	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,335,032	8,335,032	0	8,335,032	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,941,356	2,941,356	0	2,941,356	55.00
57.00	05700 CT SCAN	2,519,389	2,519,389	0	2,519,389	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,948,239	3,948,239	0	3,948,239	58.00
59.00	05900 CARDIAC CATHETERIZATION	24,481	24,481	0	24,481	59.00
60.00	06000 LABORATORY	11,045,215	11,045,215	0	11,045,215	60.00
64.00	06400 INTRAVENOUS THERAPY	1,083,631	1,083,631	0	1,083,631	64.00
65.00	06500 RESPIRATORY THERAPY	6,102,880	6,102,880	0	6,102,880	65.00
66.00	06600 PHYSICAL THERAPY	6,413,321	6,413,321	0	6,413,321	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,843,452	1,843,452	0	1,843,452	67.00
68.00	06800 SPEECH PATHOLOGY	356,455	356,455	0	356,455	68.00
69.00	06900 ELECTROCARDIOLOGY	911,542	911,542	0	911,542	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,479,123	2,479,123	0	2,479,123	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,962,594	16,962,594	0	16,962,594	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15,360,516	15,360,516	0	15,360,516	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,041,769	26,041,769	0	26,041,769	73.00
74.00	07400 RENAL DIALYSIS	1,255,855	1,255,855	0	1,255,855	74.00
76.00	03330 ENDOSCOPY	3,436,669	3,436,669	0	3,436,669	76.00
76.06	03954 IMAGING CENTER	5,144,284	5,144,284	0	5,144,284	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	6,180,244	6,180,244	0	6,180,244	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
90.26	04975 SPINE CENTER	310,907	310,907	0	310,907	90.26
91.00	09100 EMERGENCY	14,777,303	14,777,303	0	14,777,303	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,045,334	10,045,334	0	10,045,334	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW - SNF					114.00
200.00	Subtotal (see instructions)	300,631,207	300,631,207	0	300,631,207	200.00
201.00	Less Observation Beds	10,045,334	10,045,334	0	10,045,334	201.00
202.00	Total (see instructions)	290,585,873	290,585,873	0	290,585,873	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/30/2017 8:54 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	130,490,333		130,490,333				30.00
31.00	03100	INTENSIVE CARE UNIT	20,080,585		20,080,585				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	77,211,825		77,211,825				35.00
40.00	04000	SUBPROVIDER - I PF	5,051,443		5,051,443				40.00
43.00	04300	NURSERY	10,055,218		10,055,218				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	109,860,207	45,082,223	154,942,430	0.133321	0.000000		50.00
51.00	05100	RECOVERY ROOM	17,344,791	12,103,638	29,448,429	0.178077	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,486,482	0	21,486,482	0.609418	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,809,175	26,670,856	37,480,031	0.222386	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,456,117	12,537,617	23,993,734	0.122589	0.000000		55.00
57.00	05700	CT SCAN	20,702,876	45,401,129	66,104,005	0.038113	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,688,256	17,751,175	22,439,431	0.175951	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,152,710	0	1,152,710	0.021238	0.000000		59.00
60.00	06000	LABORATORY	65,279,093	40,539,920	105,819,013	0.104378	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	1,237,781	155,927	1,393,708	0.777517	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	25,047,803	2,451,012	27,498,815	0.221932	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	5,699,583	20,248,297	25,947,880	0.247162	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,535,903	2,394,644	6,930,547	0.265989	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,358,807	672,059	2,030,866	0.175519	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	6,498,249	1,472,858	7,971,107	0.114356	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,132,898	10,827,083	11,959,981	0.207285	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,724,225	20,793,578	79,517,803	0.213318	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,502,266	5,619,644	40,121,910	0.382846	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,620,811	28,562,657	99,183,468	0.262562	0.000000		73.00
74.00	07400	RENAL DIALYSIS	2,925,252	0	2,925,252	0.429315	0.000000		74.00
76.00	03330	ENDOSCOPY	3,957,776	14,573,594	18,531,370	0.185451	0.000000		76.00
76.06	03954	IMAGING CENTER	301,939	54,252,990	54,554,929	0.094295	0.000000		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	39,985	11,026,161	11,066,146	0.558482	0.000000		76.07
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.26	04975	SPI NE CENTER	300	760,624	760,924	0.408591	0.000000		90.26
91.00	09100	EMERGENCY	29,018,118	112,939,520	141,957,638	0.104097	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,151,532	9,234,951	11,386,483	0.882216	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW - SNF							114.00
200.00		Subtotal (see instructions)	753,422,339	496,072,157	1,249,494,496				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	753,422,339	496,072,157	1,249,494,496				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I/PF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.133321		50.00
51.00	05100 RECOVERY ROOM	0.178077		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.609418		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.222386		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.122589		55.00
57.00	05700 CT SCAN	0.038113		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.175951		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.021238		59.00
60.00	06000 LABORATORY	0.104378		60.00
64.00	06400 INTRAVENOUS THERAPY	0.777517		64.00
65.00	06500 RESPIRATORY THERAPY	0.221932		65.00
66.00	06600 PHYSICAL THERAPY	0.247162		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.265989		67.00
68.00	06800 SPEECH PATHOLOGY	0.175519		68.00
69.00	06900 ELECTROCARDIOLOGY	0.114356		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207285		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382846		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262562		73.00
74.00	07400 RENAL DIALYSIS	0.429315		74.00
76.00	03330 ENDOSCOPY	0.185451		76.00
76.06	03954 IMAGING CENTER	0.094295		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.558482		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.26	04975 SPINE CENTER	0.408591		90.26
91.00	09100 EMERGENCY	0.104097		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.882216		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW - SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2017 8:54 am

		Title XIX		Hospital		PPS
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	79,061,842		79,061,842	0	79,061,842 30.00
31.00	03100 INTENSIVE CARE UNIT	10,845,852		10,845,852	0	10,845,852 31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	15,496,204		15,496,204	0	15,496,204 35.00
40.00	04000 SUBPROVIDER - IPF	2,749,585		2,749,585	0	2,749,585 40.00
43.00	04300 NURSERY	5,962,762		5,962,762	0	5,962,762 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20,657,034		20,657,034	0	20,657,034 50.00
51.00	05100 RECOVERY ROOM	5,244,084		5,244,084	0	5,244,084 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,094,253		13,094,253	0	13,094,253 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,335,032		8,335,032	0	8,335,032 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,941,356		2,941,356	0	2,941,356 55.00
57.00	05700 CT SCAN	2,519,389		2,519,389	0	2,519,389 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,948,239		3,948,239	0	3,948,239 58.00
59.00	05900 CARDIAC CATHETERIZATION	24,481		24,481	0	24,481 59.00
60.00	06000 LABORATORY	11,045,215		11,045,215	0	11,045,215 60.00
64.00	06400 INTRAVENOUS THERAPY	1,083,631		1,083,631	0	1,083,631 64.00
65.00	06500 RESPIRATORY THERAPY	6,102,880	0	6,102,880	0	6,102,880 65.00
66.00	06600 PHYSICAL THERAPY	6,413,321	0	6,413,321	0	6,413,321 66.00
67.00	06700 OCCUPATIONAL THERAPY	1,843,452	0	1,843,452	0	1,843,452 67.00
68.00	06800 SPEECH PATHOLOGY	356,455	0	356,455	0	356,455 68.00
69.00	06900 ELECTROCARDIOLOGY	911,542		911,542	0	911,542 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,479,123		2,479,123	0	2,479,123 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,962,594		16,962,594	0	16,962,594 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15,360,516		15,360,516	0	15,360,516 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,041,769		26,041,769	0	26,041,769 73.00
74.00	07400 RENAL DIALYSIS	1,255,855		1,255,855	0	1,255,855 74.00
76.00	03330 ENDOSCOPY	3,436,669		3,436,669	0	3,436,669 76.00
76.06	03954 IMAGING CENTER	5,144,284		5,144,284	0	5,144,284 76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	6,180,244		6,180,244	0	6,180,244 76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
90.26	04975 SPINE CENTER	310,907		310,907	0	310,907 90.26
91.00	09100 EMERGENCY	14,777,303		14,777,303	0	14,777,303 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,045,334		10,045,334	0	10,045,334 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
114.00	11400 UTILIZATION REVIEW - SNF					
200.00	Subtotal (see instructions)	300,631,207	0	300,631,207	0	300,631,207 200.00
201.00	Less Observation Beds	10,045,334		10,045,334		10,045,334 201.00
202.00	Total (see instructions)	290,585,873	0	290,585,873	0	290,585,873 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2017 8:54 am

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	130,490,333		130,490,333		30.00
31.00	03100	INTENSIVE CARE UNIT	20,080,585		20,080,585		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	77,211,825		77,211,825		35.00
40.00	04000	SUBPROVIDER - I PF	5,051,443		5,051,443		40.00
43.00	04300	NURSERY	10,055,218		10,055,218		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	109,860,207	45,082,223	154,942,430	0.133321	50.00
51.00	05100	RECOVERY ROOM	17,344,791	12,103,638	29,448,429	0.178077	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,486,482	0	21,486,482	0.609418	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,809,175	26,670,856	37,480,031	0.222386	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,456,117	12,537,617	23,993,734	0.122589	55.00
57.00	05700	CT SCAN	20,702,876	45,401,129	66,104,005	0.038113	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,688,256	17,751,175	22,439,431	0.175951	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,152,710	0	1,152,710	0.021238	59.00
60.00	06000	LABORATORY	65,279,093	40,539,920	105,819,013	0.104378	60.00
64.00	06400	INTRAVENOUS THERAPY	1,237,781	155,927	1,393,708	0.777517	64.00
65.00	06500	RESPIRATORY THERAPY	25,047,803	2,451,012	27,498,815	0.221932	65.00
66.00	06600	PHYSICAL THERAPY	5,699,583	20,248,297	25,947,880	0.247162	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,535,903	2,394,644	6,930,547	0.265989	67.00
68.00	06800	SPEECH PATHOLOGY	1,358,807	672,059	2,030,866	0.175519	68.00
69.00	06900	ELECTROCARDIOLOGY	6,498,249	1,472,858	7,971,107	0.114356	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,132,898	10,827,083	11,959,981	0.207285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,724,225	20,793,578	79,517,803	0.213318	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,502,266	5,619,644	40,121,910	0.382846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,620,811	28,562,657	99,183,468	0.262562	73.00
74.00	07400	RENAL DIALYSIS	2,925,252	0	2,925,252	0.429315	74.00
76.00	03330	ENDOSCOPY	3,957,776	14,573,594	18,531,370	0.185451	76.00
76.06	03954	IMAGING CENTER	301,939	54,252,990	54,554,929	0.094295	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	39,985	11,026,161	11,066,146	0.558482	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.26	04975	SPI NE CENTER	300	760,624	760,924	0.408591	90.26
91.00	09100	EMERGENCY	29,018,118	112,939,520	141,957,638	0.104097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,151,532	9,234,951	11,386,483	0.882216	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
200.00		Subtotal (see instructions)	753,422,339	496,072,157	1,249,494,496		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	753,422,339	496,072,157	1,249,494,496		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 8:54 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I/PF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.133321		50.00
51.00	05100 RECOVERY ROOM	0.178077		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.609418		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.222386		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.122589		55.00
57.00	05700 CT SCAN	0.038113		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.175951		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.021238		59.00
60.00	06000 LABORATORY	0.104378		60.00
64.00	06400 INTRAVENOUS THERAPY	0.777517		64.00
65.00	06500 RESPIRATORY THERAPY	0.221932		65.00
66.00	06600 PHYSICAL THERAPY	0.247162		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.265989		67.00
68.00	06800 SPEECH PATHOLOGY	0.175519		68.00
69.00	06900 ELECTROCARDIOLOGY	0.114356		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207285		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382846		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262562		73.00
74.00	07400 RENAL DIALYSIS	0.429315		74.00
76.00	03330 ENDOSCOPY	0.185451		76.00
76.06	03954 IMAGING CENTER	0.094295		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.558482		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.26	04975 SPINE CENTER	0.408591		90.26
91.00	09100 EMERGENCY	0.104097		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.882216		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW - SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 15-0169

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

Worksheet C Part II Date/Time Prepared: 5/30/2017 8:54 am

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,657,034	2,410,197	18,246,837	0	0	50.00
51.00	05100	RECOVERY ROOM	5,244,084	540,668	4,703,416	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,094,253	1,693,459	11,400,794	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,335,032	1,315,828	7,019,204	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,941,356	714,617	2,226,739	0	0	55.00
57.00	05700	CT SCAN	2,519,389	518,101	2,001,288	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,948,239	1,029,567	2,918,672	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,481	24,643	-162	0	0	59.00
60.00	06000	LABORATORY	11,045,215	409,215	10,636,000	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,083,631	195,422	888,209	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,102,880	600,162	5,502,718	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,413,321	266,033	6,147,288	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,843,452	75,071	1,768,381	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	356,455	14,386	342,069	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	911,542	34,953	876,589	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,479,123	236,833	2,242,290	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,962,594	591,576	16,371,018	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,360,516	464,819	14,895,697	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,041,769	904,949	25,136,820	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,255,855	28,859	1,226,996	0	0	74.00
76.00	03330	ENDOSCOPY	3,436,669	700,788	2,735,881	0	0	76.00
76.06	03954	IMAGING CENTER	5,144,284	578,769	4,565,515	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	6,180,244	221,285	5,958,959	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPINE CENTER	310,907	11,304	299,603	0	0	90.26
91.00	09100	EMERGENCY	14,777,303	1,206,764	13,570,539	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,045,334	1,093,113	8,952,221	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	186,514,962	15,881,381	170,633,581	0	0	200.00
201.00		Less Observation Beds	10,045,334	1,093,113	8,952,221	0	0	201.00
202.00		Total (line 200 minus line 201)	176,469,628	14,788,268	161,681,360	0	0	202.00

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

Provider CCN: 15-0169

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

Worksheet C Part II Date/Time Prepared: 5/30/2017 8:54 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	20,657,034	154,942,430	0.133321	50.00
51.00	05100 RECOVERY ROOM	5,244,084	29,448,429	0.178077	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,094,253	21,486,482	0.609418	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,335,032	37,480,031	0.222386	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,941,356	23,993,734	0.122589	55.00
57.00	05700 CT SCAN	2,519,389	66,104,005	0.038113	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,948,239	22,439,431	0.175951	58.00
59.00	05900 CARDIAC CATHETERIZATION	24,481	1,152,710	0.021238	59.00
60.00	06000 LABORATORY	11,045,215	105,819,013	0.104378	60.00
64.00	06400 INTRAVENOUS THERAPY	1,083,631	1,393,708	0.777517	64.00
65.00	06500 RESPIRATORY THERAPY	6,102,880	27,498,815	0.221932	65.00
66.00	06600 PHYSICAL THERAPY	6,413,321	25,947,880	0.247162	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,843,452	6,930,547	0.265989	67.00
68.00	06800 SPEECH PATHOLOGY	356,455	2,030,866	0.175519	68.00
69.00	06900 ELECTROCARDIOLOGY	911,542	7,971,107	0.114356	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,479,123	11,959,981	0.207285	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,962,594	79,517,803	0.213318	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15,360,516	40,121,910	0.382846	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,041,769	99,183,468	0.262562	73.00
74.00	07400 RENAL DIALYSIS	1,255,855	2,925,252	0.429315	74.00
76.00	03330 ENDOSCOPY	3,436,669	18,531,370	0.185451	76.00
76.06	03954 IMAGING CENTER	5,144,284	54,554,929	0.094295	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	6,180,244	11,066,146	0.558482	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.26	04975 SPINE CENTER	310,907	760,924	0.408591	90.26
91.00	09100 EMERGENCY	14,777,303	141,957,638	0.104097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,045,334	11,386,483	0.882216	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW - SNF				114.00
200.00	Subtotal (sum of lines 50 thru 199)	186,514,962	1,006,605,092		200.00
201.00	Less Observation Beds	10,045,334	0		201.00
202.00	Total (line 200 minus line 201)	176,469,628	1,006,605,092		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,603,329	0	8,603,329	60,894	141.28	30.00
31.00	INTENSIVE CARE UNIT	1,622,775		1,622,775	5,460	297.21	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,587,112		1,587,112	11,195	141.77	35.00
40.00	SUBPROVIDER - IPF	264,636	0	264,636	2,501	105.81	40.00
43.00	NURSERY	772,237		772,237	7,426	103.99	43.00
200.00	Total (lines 30-199)	12,850,089		12,850,089	87,476		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	19,005	2,685,026				
31.00	INTENSIVE CARE UNIT	2,134	634,246				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	1,868	197,653				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	23,007	3,516,925				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0169

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

Worksheet D
Part II
Date/Time Prepared:
5/30/2017 8:54 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	2,410,197	154,942,430	0.015555	40,796,221	634,585	50.00
51.00	05100	RECOVERY ROOM	540,668	29,448,429	0.018360	4,933,442	90,578	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,693,459	21,486,482	0.078815	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315,828	37,480,031	0.035107	4,191,689	147,158	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	714,617	23,993,734	0.029783	5,008,132	149,157	55.00
57.00	05700	CT SCAN	518,101	66,104,005	0.007838	8,208,792	64,341	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,029,567	22,439,431	0.045882	2,061,205	94,572	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,643	1,152,710	0.021378	422,852	9,040	59.00
60.00	06000	LABORATORY	409,215	105,819,013	0.003867	24,682,843	95,449	60.00
64.00	06400	INTRAVENOUS THERAPY	195,422	1,393,708	0.140217	458,578	64,300	64.00
65.00	06500	RESPIRATORY THERAPY	600,162	27,498,815	0.021825	7,196,435	157,062	65.00
66.00	06600	PHYSICAL THERAPY	266,033	25,947,880	0.010253	2,658,684	27,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,071	6,930,547	0.010832	1,900,238	20,583	67.00
68.00	06800	SPEECH PATHOLOGY	14,386	2,030,866	0.007084	581,408	4,119	68.00
69.00	06900	ELECTROCARDIOLOGY	34,953	7,971,107	0.004385	2,928,758	12,843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	236,833	11,959,981	0.019802	377,064	7,467	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	591,576	79,517,803	0.007440	13,322,325	99,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	464,819	40,121,910	0.011585	14,529,357	168,323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	904,949	99,183,468	0.009124	25,856,639	235,916	73.00
74.00	07400	RENAL DIALYSIS	28,859	2,925,252	0.009865	1,624,887	16,030	74.00
76.00	03330	ENDOSCOPY	700,788	18,531,370	0.037816	229,231	8,669	76.00
76.06	03954	IMAGING CENTER	578,769	54,554,929	0.010609	17,127	182	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	221,285	11,066,146	0.019997	423	8	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.26	04975	SPI NE CENTER	11,304	760,924	0.014856	0	0	90.26
91.00	09100	EMERGENCY	1,206,764	141,957,638	0.008501	13,109,807	111,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,093,113	11,386,483	0.096001	679,495	65,232	92.00
200.00		Total (lines 50-199)	15,881,381	1,006,605,092		175,775,632	2,283,437	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,894	0.00	19,005	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,460	0.00	2,134	0		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,195	0.00	0	0		35.00
40.00	04000	SUBPROVIDER - IPF	2,501	0.00	1,868	0		40.00
43.00	04300	NURSERY	7,426	0.00	0	0		43.00
200.00		Total (lines 30-199)	87,476		23,007	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.26	04975	SPINE CENTER	0	0	0	0	90.26
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 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)	Hospital		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	154,942,430	0.000000	0.000000	40,796,221	50.00
51.00	05100	RECOVERY ROOM	0	29,448,429	0.000000	0.000000	4,933,442	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,486,482	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,480,031	0.000000	0.000000	4,191,689	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	23,993,734	0.000000	0.000000	5,008,132	55.00
57.00	05700	CT SCAN	0	66,104,005	0.000000	0.000000	8,208,792	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,439,431	0.000000	0.000000	2,061,205	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,152,710	0.000000	0.000000	422,852	59.00
60.00	06000	LABORATORY	0	105,819,013	0.000000	0.000000	24,682,843	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,393,708	0.000000	0.000000	458,578	64.00
65.00	06500	RESPIRATORY THERAPY	0	27,498,815	0.000000	0.000000	7,196,435	65.00
66.00	06600	PHYSICAL THERAPY	0	25,947,880	0.000000	0.000000	2,658,684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,930,547	0.000000	0.000000	1,900,238	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,030,866	0.000000	0.000000	581,408	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,971,107	0.000000	0.000000	2,928,758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,959,981	0.000000	0.000000	377,064	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,517,803	0.000000	0.000000	13,322,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,121,910	0.000000	0.000000	14,529,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	99,183,468	0.000000	0.000000	25,856,639	73.00
74.00	07400	RENAL DIALYSIS	0	2,925,252	0.000000	0.000000	1,624,887	74.00
76.00	03330	ENDOSCOPY	0	18,531,370	0.000000	0.000000	229,231	76.00
76.06	03954	IMAGING CENTER	0	54,554,929	0.000000	0.000000	17,127	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	11,066,146	0.000000	0.000000	423	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.26	04975	SPINE CENTER	0	760,924	0.000000	0.000000	0	90.26
91.00	09100	EMERGENCY	0	141,957,638	0.000000	0.000000	13,109,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,386,483	0.000000	0.000000	679,495	92.00
200.00		Total (lines 50-199)	0	1,006,605,092			175,775,632	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII						
		Hospital			PPS	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,864,067	0	50.00
51.00	05100	RECOVERY ROOM	0	1,509,413	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,028,589	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,785,743	0	55.00
57.00	05700	CT SCAN	0	9,293,651	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,658,296	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	7,251,197	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	254,222	0	65.00
66.00	06600	PHYSICAL THERAPY	0	62,607	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53,877	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,504	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	269,719	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,374,945	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,340,050	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,817,692	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,564,757	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	4,370,901	0	76.00
76.06	03954	IMAGING CENTER	0	13,148,847	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	706,190	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.26	04975	SPI NE CENTER	0	3,145	0	90.26
91.00	09100	EMERGENCY	0	15,299,846	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,860,051	0	92.00
200.00		Total (lines 50-199)	0	90,530,309	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.133321	7,864,067	0	0	1,048,445	50.00
51.00	05100	RECOVERY ROOM	0.178077	1,509,413	0	0	268,792	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609418	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222386	5,028,589	0	0	1,118,288	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.122589	5,785,743	0	0	709,268	55.00
57.00	05700	CT SCAN	0.038113	9,293,651	0	0	354,209	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.175951	3,658,296	0	0	643,681	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.021238	0	0	0	0	59.00
60.00	06000	LABORATORY	0.104378	7,251,197	381	0	756,865	60.00
64.00	06400	INTRAVENOUS THERAPY	0.777517	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.221932	254,222	0	0	56,420	65.00
66.00	06600	PHYSICAL THERAPY	0.247162	62,607	0	0	15,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265989	53,877	0	0	14,331	67.00
68.00	06800	SPEECH PATHOLOGY	0.175519	12,504	0	0	2,195	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114356	269,719	0	0	30,844	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.207285	2,374,945	0	0	492,290	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318	3,340,050	0	0	712,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382846	1,817,692	0	0	695,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262562	5,564,757	0	163,067	1,461,094	73.00
74.00	07400	RENAL DIALYSIS	0.429315	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.185451	4,370,901	0	0	810,588	76.00
76.06	03954	IMAGING CENTER	0.094295	13,148,847	0	0	1,239,871	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.558482	706,190	0	0	394,394	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.26	04975	SPINE CENTER	0.408591	3,145	0	0	1,285	90.26
91.00	09100	EMERGENCY	0.104097	15,299,846	0	0	1,592,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.882216	2,860,051	0	0	2,523,183	92.00
200.00		Subtotal (see instructions)		90,530,309	381	163,067	14,942,574	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		90,530,309	381	163,067	14,942,574	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	40	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	42,815	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	76.00
76.06	03954 IMAGING CENTER	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	76.07
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.26	04975 SPINE CENTER	0	0	90.26
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)	40	42,815	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	40	42,815	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/30/2017 8:54 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	2,410,197	154,942,430	0.015555	0	0	50.00
51.00 05100 RECOVERY ROOM	540,668	29,448,429	0.018360	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,693,459	21,486,482	0.078815	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,315,828	37,480,031	0.035107	23,280	817	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	714,617	23,993,734	0.029783	0	0	55.00
57.00 05700 CT SCAN	518,101	66,104,005	0.007838	42,096	330	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,029,567	22,439,431	0.045882	3,295	151	58.00
59.00 05900 CARDIAC CATHETERIZATION	24,643	1,152,710	0.021378	0	0	59.00
60.00 06000 LABORATORY	409,215	105,819,013	0.003867	501,090	1,938	60.00
64.00 06400 INTRAVENOUS THERAPY	195,422	1,393,708	0.140217	26,878	3,769	64.00
65.00 06500 RESPIRATORY THERAPY	600,162	27,498,815	0.021825	17,942	392	65.00
66.00 06600 PHYSICAL THERAPY	266,033	25,947,880	0.010253	71,361	732	66.00
67.00 06700 OCCUPATIONAL THERAPY	75,071	6,930,547	0.010832	49,850	540	67.00
68.00 06800 SPEECH PATHOLOGY	14,386	2,030,866	0.007084	7,243	51	68.00
69.00 06900 ELECTROCARDIOLOGY	34,953	7,971,107	0.004385	9,416	41	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	236,833	11,959,981	0.019802	10,132	201	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	591,576	79,517,803	0.007440	18,437	137	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	464,819	40,121,910	0.011585	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	904,949	99,183,468	0.009124	375,806	3,429	73.00
74.00 07400 RENAL DIALYSIS	28,859	2,925,252	0.009865	0	0	74.00
76.00 03330 ENDOSCOPY	700,788	18,531,370	0.037816	0	0	76.00
76.06 03954 IMAGING CENTER	578,769	54,554,929	0.010609	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	221,285	11,066,146	0.019997	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0	0	90.00
90.26 04975 SPINE CENTER	11,304	760,924	0.014856	0	0	90.26
91.00 09100 EMERGENCY	1,206,764	141,957,638	0.008501	159,941	1,360	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11,386,483	0.000000	9,079	0	92.00
200.00 Total (lines 50-199)	14,788,268	1,006,605,092		1,325,846	13,888	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
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	Title XVIII	Subprovider - IPF	PPS
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.26	04975	SPINE CENTER	0	0	0	0	90.26
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	154,942,430	0.000000	0.000000	0 50.00
51.00 05100 RECOVERY ROOM	0	29,448,429	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	21,486,482	0.000000	0.000000	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	37,480,031	0.000000	0.000000	23,280 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	23,993,734	0.000000	0.000000	0 55.00
57.00 05700 CT SCAN	0	66,104,005	0.000000	0.000000	42,096 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	22,439,431	0.000000	0.000000	3,295 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	1,152,710	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	105,819,013	0.000000	0.000000	501,090 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,393,708	0.000000	0.000000	26,878 64.00
65.00 06500 RESPIRATORY THERAPY	0	27,498,815	0.000000	0.000000	17,942 65.00
66.00 06600 PHYSICAL THERAPY	0	25,947,880	0.000000	0.000000	71,361 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	6,930,547	0.000000	0.000000	49,850 67.00
68.00 06800 SPEECH PATHOLOGY	0	2,030,866	0.000000	0.000000	7,243 68.00
69.00 06900 ELECTROCARDIOLOGY	0	7,971,107	0.000000	0.000000	9,416 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	11,959,981	0.000000	0.000000	10,132 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,517,803	0.000000	0.000000	18,437 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	40,121,910	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	99,183,468	0.000000	0.000000	375,806 73.00
74.00 07400 RENAL DIALYSIS	0	2,925,252	0.000000	0.000000	0 74.00
76.00 03330 ENDOSCOPY	0	18,531,370	0.000000	0.000000	0 76.00
76.06 03954 IMAGING CENTER	0	54,554,929	0.000000	0.000000	0 76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	11,066,146	0.000000	0.000000	0 76.07
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0 90.00
90.26 04975 SPINE CENTER	0	760,924	0.000000	0.000000	0 90.26
91.00 09100 EMERGENCY	0	141,957,638	0.000000	0.000000	159,941 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11,386,483	0.000000	0.000000	9,079 92.00
200.00 Total (lines 50-199)	0	1,006,605,092			1,325,846 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 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)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	0	76.00
76.06	03954 IMAGING CENTER	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.26	04975 SPINE CENTER	0	0	0	90.26
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 8:54 am
Title XVIII			Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.133321	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0.178077	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0.609418	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.222386	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0.122589	0	0	0	55.00
57.00 05700	CT SCAN	0.038113	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0.175951	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0.021238	0	0	0	59.00
60.00 06000	LABORATORY	0.104378	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0.777517	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0.221932	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0.247162	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0.265989	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0.175519	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0.114356	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.207285	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.382846	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.262562	0	2,956	0	73.00
74.00 07400	RENAL DIALYSIS	0.429315	0	0	0	74.00
76.00 03330	ENDOSCOPY	0.185451	0	0	0	76.00
76.06 03954	IMAGING CENTER	0.094295	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0.558482	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0.000000	0	0	0	90.00
90.26 04975	SPI NE CENTER	0.408591	0	0	0	90.26
91.00 09100	EMERGENCY	0.104097	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.882216	0	0	1,281	92.00
200.00	Subtotal (see instructions)		0	2,956	1,281	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	2,956	1,281	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 8:54 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	776	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	76.00
76.06 03954 IMAGING CENTER	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	76.07
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.26 04975 SPINE CENTER	0	0	90.26
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,130	92.00
200.00 Subtotal (see instructions)	776	1,130	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	776	1,130	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Title XIX			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	8,603,329	0	8,603,329	60,894	141.28	30.00	
31.00	INTENSIVE CARE UNIT	1,622,775		1,622,775	5,460	297.21	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	1,587,112		1,587,112	11,195	141.77	35.00	
40.00	SUBPROVIDER - IPF	264,636	0	264,636	2,501	105.81	40.00	
43.00	NURSERY	772,237		772,237	7,426	103.99	43.00	
200.00	Total (lines 30-199)	12,850,089		12,850,089	87,476		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	2,098	296,405					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
35.00	NEONATAL INTENSIVE CARE UNIT	46	6,521					35.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	3,314	344,623					43.00
200.00	Total (lines 30-199)	5,458	647,549					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Title XIX			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	2,410,197	154,942,430	0.015555	1,145,454	17,818	50.00
51.00	05100	RECOVERY ROOM	540,668	29,448,429	0.018360	156,909	2,881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,693,459	21,486,482	0.078815	362,359	28,559	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315,828	37,480,031	0.035107	337,140	11,836	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	714,617	23,993,734	0.029783	159,371	4,747	55.00
57.00	05700	CT SCAN	518,101	66,104,005	0.007838	341,868	2,680	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,029,567	22,439,431	0.045882	97,932	4,493	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,643	1,152,710	0.021378	0	0	59.00
60.00	06000	LABORATORY	409,215	105,819,013	0.003867	1,521,488	5,884	60.00
64.00	06400	INTRAVENOUS THERAPY	195,422	1,393,708	0.140217	24,591	3,448	64.00
65.00	06500	RESPIRATORY THERAPY	600,162	27,498,815	0.021825	1,232,411	26,897	65.00
66.00	06600	PHYSICAL THERAPY	266,033	25,947,880	0.010253	65,639	673	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,071	6,930,547	0.010832	153,744	1,665	67.00
68.00	06800	SPEECH PATHOLOGY	14,386	2,030,866	0.007084	67,117	475	68.00
69.00	06900	ELECTROCARDIOLOGY	34,953	7,971,107	0.004385	122,072	535	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	236,833	11,959,981	0.019802	22,049	437	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	591,576	79,517,803	0.007440	727,831	5,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	464,819	40,121,910	0.011585	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	904,949	99,183,468	0.009124	1,747,572	15,945	73.00
74.00	07400	RENAL DIALYSIS	28,859	2,925,252	0.009865	17,570	173	74.00
76.00	03330	ENDOSCOPY	700,788	18,531,370	0.037816	21,560	815	76.00
76.06	03954	IMAGING CENTER	578,769	54,554,929	0.010609	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	221,285	11,066,146	0.019997	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.26	04975	SPI NE CENTER	11,304	760,924	0.014856	0	0	90.26
91.00	09100	EMERGENCY	1,206,764	141,957,638	0.008501	417,607	3,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,093,113	11,386,483	0.096001	136,994	13,152	92.00
200.00		Total (lines 50-199)	15,881,381	1,006,605,092		8,879,278	152,078	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description			Title XIX			Hospital		PPS
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,894	0.00	2,098	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,460	0.00	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,195	0.00	46	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	2,501	0.00	0	0	0	40.00
43.00	04300	NURSERY	7,426	0.00	3,314	0	0	43.00
200.00		Total (lines 30-199)	87,476		5,458	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description	Title XIX				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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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	03330	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03954	IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.26	04975	SPINE CENTER	0	0	0	0	0	90.26
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: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	154,942,430	0.000000	0.000000	1,145,454	50.00
51.00	05100	RECOVERY ROOM	0	29,448,429	0.000000	0.000000	156,909	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,486,482	0.000000	0.000000	362,359	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,480,031	0.000000	0.000000	337,140	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	23,993,734	0.000000	0.000000	159,371	55.00
57.00	05700	CT SCAN	0	66,104,005	0.000000	0.000000	341,868	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,439,431	0.000000	0.000000	97,932	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,152,710	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	105,819,013	0.000000	0.000000	1,521,488	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,393,708	0.000000	0.000000	24,591	64.00
65.00	06500	RESPIRATORY THERAPY	0	27,498,815	0.000000	0.000000	1,232,411	65.00
66.00	06600	PHYSICAL THERAPY	0	25,947,880	0.000000	0.000000	65,639	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,930,547	0.000000	0.000000	153,744	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,030,866	0.000000	0.000000	67,117	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,971,107	0.000000	0.000000	122,072	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,959,981	0.000000	0.000000	22,049	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,517,803	0.000000	0.000000	727,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,121,910	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	99,183,468	0.000000	0.000000	1,747,572	73.00
74.00	07400	RENAL DIALYSIS	0	2,925,252	0.000000	0.000000	17,570	74.00
76.00	03330	ENDOSCOPY	0	18,531,370	0.000000	0.000000	21,560	76.00
76.06	03954	IMAGING CENTER	0	54,554,929	0.000000	0.000000	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	11,066,146	0.000000	0.000000	0	76.07
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.26	04975	SPINE CENTER	0	760,924	0.000000	0.000000	0	90.26
91.00	09100	EMERGENCY	0	141,957,638	0.000000	0.000000	417,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,386,483	0.000000	0.000000	136,994	92.00
200.00		Total (lines 50-199)	0	1,006,605,092			8,879,278	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 8:54 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03330 ENDOSCOPY	0	0	0		76.00
76.06	03954 IMAGING CENTER	0	0	0		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0		76.07
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.26	04975 SPINE CENTER	0	0	0		90.26
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 8:54 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.133321	0	562,514	0	0	50.00
51.00	05100 RECOVERY ROOM	0.178077	0	47,470	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.609418	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.222386	0	589,701	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.122589	0	44,974	0	0	55.00
57.00	05700 CT SCAN	0.038113	0	730,514	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.175951	0	132,501	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.021238	0	0	0	0	59.00
60.00	06000 LABORATORY	0.104378	0	972,473	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.777517	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.221932	0	70,931	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.247162	0	57,277	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.265989	0	27,612	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.175519	0	29,185	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.114356	0	22,403	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207285	0	37,481	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318	0	197,480	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382846	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262562	0	366,801	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.429315	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.185451	0	109,291	0	0	76.00
76.06	03954 IMAGING CENTER	0.094295	0	200,229	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.558482	0	27,645	0	0	76.07
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.26	04975 SPINE CENTER	0.408591	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.104097	0	3,623,565	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.882216	0	411,820	0	0	92.00
200.00	Subtotal (see instructions)		0	8,261,867	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	8,261,867	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 8:54 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	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	74,995	0		50.00
51.00 05100 RECOVERY ROOM	8,453	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	131,141	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	5,513	0		55.00
57.00 05700 CT SCAN	27,842	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	23,314	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	101,505	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	15,742	0		65.00
66.00 06600 PHYSICAL THERAPY	14,157	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	7,344	0		67.00
68.00 06800 SPEECH PATHOLOGY	5,123	0		68.00
69.00 06900 ELECTROCARDIOLOGY	2,562	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	7,769	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42,126	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	96,308	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	20,268	0		76.00
76.06 03954 IMAGING CENTER	18,881	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	15,439	0		76.07
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.26 04975 SPINE CENTER	0	0		90.26
91.00 09100 EMERGENCY	377,202	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	363,314	0		92.00
200.00 Subtotal (see instructions)	1,358,998	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,358,998	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 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)		60,894	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		60,894	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)		53,157	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)		19,005	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)		79,061,842	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)		79,061,842	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)		79,061,842	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)		1,298.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		24,675,142	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)		24,675,142	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	10,845,852	5,460	1,986.42	2,134	4,239,020	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	NEONATAL INTENSIVE CARE UNIT	15,496,204	11,195	1,384.21	0	0	47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					32,655,341	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					61,569,503	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)					3,319,272	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,283,437	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,602,709	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					55,966,794	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)					7,737	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,298.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,045,334	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,603,329	79,061,842	0.108818	10,045,334	1,093,113	90.00
91.00	Nursing School cost	0	79,061,842	0.000000	10,045,334	0	91.00
92.00	Allied health cost	0	79,061,842	0.000000	10,045,334	0	92.00
93.00	All other Medical Education	0	79,061,842	0.000000	10,045,334	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 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)		2,501	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,501	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)		2,501	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,868	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,749,585	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,749,585	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,749,585	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)		1,099.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,053,661	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)		2,053,661	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1	
				Component CCN: 15-S169		Date/Time Prepared: 5/30/2017 8:54 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						247,154	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,300,815	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)						197,653	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						13,888	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						211,541	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,089,274	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 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	264,636	2,749,585	0.096246	0	0	90.00
91.00	Nursing School cost	0	2,749,585	0.000000	0	0	91.00
92.00	Allied health cost	0	2,749,585	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,749,585	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		60,894	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		60,894	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)		53,157	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)		2,098	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)		7,426	15.00
16.00	Nursery days (title V or XIX only)		3,314	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)		79,061,842	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)		79,061,842	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)		79,061,842	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)		1,298.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,723,938	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)		2,723,938	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description			Title XIX		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	1.00	2.00	3.00	4.00	5.00	
NURSERY (title V & XIX only)						
	5,962,762	7,426	802.96	3,314	2,661,009	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	10,845,852	5,460	1,986.42	0	0	43.00
44.00						44.00
45.00						45.00
46.00						46.00
47.00	15,496,204	11,195	1,384.21	46	63,674	47.00
Cost Center Description						
					1.00	
48.00					1,855,100	48.00
49.00					7,303,721	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00					647,549	50.00
51.00					152,078	51.00
52.00					799,627	52.00
53.00					6,504,094	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00					0	54.00
55.00					0.00	55.00
56.00					0	56.00
57.00					0	57.00
58.00					0	58.00
59.00					0.00	59.00
60.00					0.00	60.00
61.00					0	61.00
62.00					0	62.00
63.00					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00					0	64.00
65.00					0	65.00
66.00					0	66.00
67.00					0	67.00
68.00					0	68.00
69.00					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00						70.00
71.00						71.00
72.00						72.00
73.00						73.00
74.00						74.00
75.00						75.00
76.00						76.00
77.00						77.00
78.00						78.00
79.00						79.00
80.00						80.00
81.00						81.00
82.00						82.00
83.00						83.00
84.00						84.00
85.00						85.00
86.00						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00					7,737	87.00
88.00					1,298.35	88.00
89.00					10,045,334	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 8:54 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,603,329	79,061,842	0.108818	10,045,334	1,093,113	90.00
91.00	Nursing School cost	0	79,061,842	0.000000	10,045,334	0	91.00
92.00	Allied health cost	0	79,061,842	0.000000	10,045,334	0	92.00
93.00	All other Medical Education	0	79,061,842	0.000000	10,045,334	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 8:54 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		33,006,266	30.00
31.00	03100	INTENSIVE CARE UNIT		7,847,206	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.133321	40,796,221	5,438,993 50.00
51.00	05100	RECOVERY ROOM	0.178077	4,933,442	878,533 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609418	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222386	4,191,689	932,173 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.122589	5,008,132	613,942 55.00
57.00	05700	CT SCAN	0.038113	8,208,792	312,862 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.175951	2,061,205	362,671 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.021238	422,852	8,981 59.00
60.00	06000	LABORATORY	0.104378	24,682,843	2,576,346 60.00
64.00	06400	INTRAVENOUS THERAPY	0.777517	458,578	356,552 64.00
65.00	06500	RESPIRATORY THERAPY	0.221932	7,196,435	1,597,119 65.00
66.00	06600	PHYSICAL THERAPY	0.247162	2,658,684	657,126 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265989	1,900,238	505,442 67.00
68.00	06800	SPEECH PATHOLOGY	0.175519	581,408	102,048 68.00
69.00	06900	ELECTROCARDIOLOGY	0.114356	2,928,758	334,921 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.207285	377,064	78,160 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318	13,322,325	2,841,892 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382846	14,529,357	5,562,506 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262562	25,856,639	6,788,971 73.00
74.00	07400	RENAL DIALYSIS	0.429315	1,624,887	697,588 74.00
76.00	03330	ENDOSCOPY	0.185451	229,231	42,511 76.00
76.06	03954	IMAGING CENTER	0.094295	17,127	1,615 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.558482	423	236 76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.26	04975	SPI NE CENTER	0.408591	0	0 90.26
91.00	09100	EMERGENCY	0.104097	13,109,807	1,364,692 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.882216	679,495	599,461 92.00
200.00		Total (sum of lines 50-94 and 96-98)		175,775,632	32,655,341 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		175,775,632	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 8:54 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		3,763,986	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.133321	0	50.00
51.00	05100	RECOVERY ROOM	0.178077	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609418	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222386	23,280	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.122589	0	55.00
57.00	05700	CT SCAN	0.038113	42,096	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.175951	3,295	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.021238	0	59.00
60.00	06000	LABORATORY	0.104378	501,090	60.00
64.00	06400	INTRAVENOUS THERAPY	0.777517	26,878	64.00
65.00	06500	RESPIRATORY THERAPY	0.221932	17,942	65.00
66.00	06600	PHYSICAL THERAPY	0.247162	71,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265989	49,850	67.00
68.00	06800	SPEECH PATHOLOGY	0.175519	7,243	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114356	9,416	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.207285	10,132	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318	18,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382846	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262562	375,806	73.00
74.00	07400	RENAL DIALYSIS	0.429315	0	74.00
76.00	03330	ENDOSCOPY	0.185451	0	76.00
76.06	03954	IMAGING CENTER	0.094295	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.558482	0	76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.26	04975	SPINE CENTER	0.408591	0	90.26
91.00	09100	EMERGENCY	0.104097	159,941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.882216	9,079	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,325,846	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)		1,325,846	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 8:54 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		2,683,711	30.00
31.00	03100	INTENSIVE CARE UNIT		663,948	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		9,681,862	35.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
43.00	04300	NURSERY		404,502	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.133321	1,145,454	152,713 50.00
51.00	05100	RECOVERY ROOM	0.178077	156,909	27,942 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609418	362,359	220,828 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222386	337,140	74,975 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.122589	159,371	19,537 55.00
57.00	05700	CT SCAN	0.038113	341,868	13,030 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.175951	97,932	17,231 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.021238	0	0 59.00
60.00	06000	LABORATORY	0.104378	1,521,488	158,810 60.00
64.00	06400	INTRAVENOUS THERAPY	0.777517	24,591	19,120 64.00
65.00	06500	RESPIRATORY THERAPY	0.221932	1,232,411	273,511 65.00
66.00	06600	PHYSICAL THERAPY	0.247162	65,639	16,223 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265989	153,744	40,894 67.00
68.00	06800	SPEECH PATHOLOGY	0.175519	67,117	11,780 68.00
69.00	06900	ELECTROCARDIOLOGY	0.114356	122,072	13,960 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.207285	22,049	4,570 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213318	727,831	155,259 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382846	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262562	1,747,572	458,846 73.00
74.00	07400	RENAL DIALYSIS	0.429315	17,570	7,543 74.00
76.00	03330	ENDOSCOPY	0.185451	21,560	3,998 76.00
76.06	03954	IMAGING CENTER	0.094295	0	0 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.558482	0	0 76.07
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.26	04975	SPI NE CENTER	0.408591	0	0 90.26
91.00	09100	EMERGENCY	0.104097	417,607	43,472 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.882216	136,994	120,858 92.00
200.00		Total (sum of lines 50-94 and 96-98)		8,879,278	1,855,100 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		8,879,278	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 8:54 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)		31,109,519	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,637,475	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)		1,287,452	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		13,669,013	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		269.94	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).		2.95	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)		2.95	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.22	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.16	11.00
12.00	Current year allowable FTE (see instructions)		4.38	12.00
13.00	Total allowable FTE count for the prior year.		2.52	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.		0.87	14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.59	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		2.59	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.009595	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.005730	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.005730	21.00
22.00	IME payment adjustment (see instructions)		127,457	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		42,757	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)		-0.73	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)		127,457	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		42,757	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.12	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.39	31.00
32.00	Sum of lines 30 and 31		29.51	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.56	33.00
34.00	Disproportionate share adjustment (see instructions)		1,381,324	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 8:54 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)	0.000483842	0.000471897	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,099,562	2,820,755	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,320,437	710,985	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,031,422		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)	46,574,649		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)		46,617,406	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,647,054	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).		84,025	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)		50,348,485	59.00
60.00	Primary payer payments		10,580	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		50,337,905	61.00
62.00	Deductibles billed to program beneficiaries		4,010,784	62.00
63.00	Coinurance billed to program beneficiaries		117,208	63.00
64.00	Allowable bad debts (see instructions)		256,049	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		166,432	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		165,296	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		46,376,345	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)		-20,727	70.93
70.94	HRR adjustment amount (see instructions)		-82,492	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 8:54 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		117,467		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		46,155,659		71.00
71.01	Sequestration adjustment (see instructions)		923,113		71.01
72.00	Interim payments		45,640,045		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)		-407,499		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		7,383,208		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0		104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			42,855 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			14,942,574 2.00
3.00	PPS payments			12,180,833 3.00
4.00	Outlier payment (see instructions)			25,378 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)			42,855 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			163,448 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)			163,448 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)			163,448 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			120,593 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)			42,855 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)			12,206,211 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)			2,604,976 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)			9,644,090 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			19,713 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)			9,663,803 30.00
31.00	Primary payer payments			4,853 31.00
32.00	Subtotal (line 30 minus line 31)			9,658,950 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)			255,326 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			165,962 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			212,405 36.00
37.00	Subtotal (see instructions)			9,824,912 37.00
38.00	MSP-LCC reconciliation amount from PS&R			366 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)			9,824,546 40.00
40.01	Sequestration adjustment (see instructions)			196,491 40.01
41.00	Interim payments			9,654,812 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-26,757 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			1,906 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			460 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			1,906 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			4,237 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)			4,237 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)			4,237 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			2,331 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)			1,906 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)			460 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			0 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,366 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)			2,366 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			2,366 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			2,366 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)			2,366 40.00
40.01	Sequestration adjustment (see instructions)			47 40.01
41.00	Interim payments			1,175 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			1,144 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0169

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2017 8:54 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		45,551,045		9,621,812	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	07/01/2016	89,000	07/01/2016	33,000	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		89,000		33,000	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)		45,640,045		9,654,812	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		407,499		26,757	6.02	
7.00	Total Medicare program liability (see instructions)		45,232,546		9,628,055	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: 15-0169
Component CCN: 15-S169

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2017 8:54 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					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,591,200		1,175	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,591,200		1,175	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		850		1,144	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,592,050		2,319	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 8:54 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		16,256	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		21,139	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		7,159	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		69,812	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		1,249,494,496	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		2,034,638	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/30/2017 8:54 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)			1,783,902 1.00
2.00	Net IPF PPS Outlier Payments			0 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)			6.833333 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,783,902 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,783,902 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,783,902 18.00
19.00	Deductibles			155,708 19.00
20.00	Subtotal (line 18 minus line 19)			1,628,194 20.00
21.00	Coinsurance			4,508 21.00
22.00	Subtotal (line 20 minus line 21)			1,623,686 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,316 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			855 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			90 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,624,541 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,624,541 31.00
31.01	Sequestration adjustment (see instructions)			32,491 31.01
32.00	Interim payments			1,591,200 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)			850 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			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/30/2017 8:54 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			2.95	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			2.95	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.39	6.00
7.00	Enter the lesser of line 5 or line 6			2.95	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	1.55	0.67	2.22	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	1.04	0.45	1.49	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.16		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	1.04	2.61		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.78	1.62		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.68	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.50	1.41		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	1.50	1.41		17.00
18.00	Per resident amount	89,817.80	89,817.80		18.00
19.00	Approved amount for resident costs	134,727	126,643	261,370	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			1.44	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			261,370	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	23,007	7,159		26.00
27.00	Total Inpatient Days (see instructions)	73,455	73,455		27.00
28.00	Ratio of inpatient days to total inpatient days	0.313212	0.097461		28.00
29.00	Program direct GME amount	81,864	25,473		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		3,599		30.00
31.00	Net Program direct GME amount			103,738	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		2,925,252	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		63,870,318	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		10,580	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		63,859,738	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		14,987,335	42.00
43.00	Primary payer payments (see instructions)		4,853	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		14,982,482	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		78,842,220	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.809969	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.190031	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		103,738	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		84,025	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		19,713	50.00

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

Provider CCN: 15-0169

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

Worksheet G

Date/Time Prepared: 5/30/2017 8:54 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	3,650	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	792,528,431	0	0	0	4.00
5.00	Other receivable	500	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-185,975,690	0	0	0	6.00
7.00	Inventory	4,681,697	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	296,029	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)	611,534,617	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,705,851	0	0	0	12.00
13.00	Land improvements	3,158,137	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	301,703,922	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,321,040	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	102,172,275	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-197,851,665	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	316,270	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	213,525,830	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	91,645,315	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	91,645,315	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	916,705,762	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	507,389	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	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	3,059,173	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,566,562	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,566,562	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	913,139,200				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	913,139,200	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	916,705,762	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

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

Worksheet G-1

Date/Time Prepared:
5/30/2017 8:54 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		811,803,459		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		101,335,741			2.00
3.00	Total (sum of line 1 and line 2)		913,139,200		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		913,139,200		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		913,139,200		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0169

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2017 8:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	139,308,889		139,308,889	1.00
2.00	SUBPROVIDER - IPF	5,043,178		5,043,178	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)	144,352,067		144,352,067	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,290,223		21,290,223	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	NEONATAL INTENSIVE CARE UNIT	80,556,994		80,556,994	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	101,847,217		101,847,217	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	246,199,284		246,199,284	17.00
18.00	Ancillary services	501,832,385	540,667,996	1,042,500,381	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	748,031,669	540,667,996	1,288,699,665	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		321,939,003		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		321,939,003		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0169

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

Worksheet G-3

Date/Time Prepared:
5/30/2017 8:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,288,699,665	1.00
2.00	Less contractual allowances and discounts on patients' accounts	867,905,533	2.00
3.00	Net patient revenues (line 1 minus line 2)	420,794,132	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	321,939,003	4.00
5.00	Net income from service to patients (line 3 minus line 4)	98,855,129	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	19,671	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	2,460,941	24.00
25.00	Total other income (sum of lines 6-24)	2,480,612	25.00
26.00	Total (line 5 plus line 25)	101,335,741	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)	101,335,741	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/30/2017 8:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,275,146	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		158,041	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)		199.66	3.00
4.00	Number of interns & residents (see instructions)		2.59	4.00
5.00	Indirect medical education percentage (see instructions)		0.37	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)		12,118	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.12	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		26.39	8.00
9.00	Sum of lines 7 and 8		29.51	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.16	10.00
11.00	Disproportionate share adjustment (see instructions)		201,749	11.00
12.00	Total prospective capital payments (see instructions)		3,647,054	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