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: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 1:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2017 Time: 1:53 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 FRANCISCAN HEALTH MUNSTER (15-0165) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	34,501	120,673	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	34,501	120,673	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 1:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 701 SUPERIOR STREET	PO Box:			1.00
2.00	City: MUNSTER	State: IN	Zip Code: 46321	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANCISCAN HEALTH MUNSTER	150165	23844	1	06/01/2007	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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	N	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.	2	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.	802	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)	Y	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 1:49 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	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	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 1:49 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	168,093	187,001	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 1:49 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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: FRANCISCAN ALLIANCE,	Contractor's Name: WISCONSIN PHYSICIAN SERVICE	Contractor's Number: 8001	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box:		142.00
143.00	City: MISHAWAKA	State:	Zip Code: 46546	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		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	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	03/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2017 1:49 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	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	05/03/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	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.			Y	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	04/04/2017	Y	04/04/2017 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 1:49 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HONG		YANG		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ST. MARGARET HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-932-2300 X33175		HONG.YANG@FRANCISCANALLIANCE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 1:49 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 1:49 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	54	19,764	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)		54	19,764	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,294	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		63	23,058	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						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)		63				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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 1:49 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,208	655	6,088			1.00
2.00	HMO and other (see instructions)	776	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,208	655	6,088			7.00
8.00	INTENSIVE CARE UNIT	309	147	1,888			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,517	802	7,976	0.00	334.86	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	334.86	27.00
28.00	Observation Bed Days		281	2,450			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 1:49 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	797	161	1,836	1.00
2.00	HMO and other (see instructions)			166	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	797	161	1,836	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2017 1:49 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	21,836,540	0	21,836,540	696,519.00	31.35	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		441,808	0	441,808	1,676.00	263.61	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		465,581	0	465,581	7,420.00	62.75	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		198,199	0	198,199	1,523.00	130.14	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		4,728,228	0	4,728,228	176,547.00	26.78	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,614,738	0	4,614,738			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		95,296	0	95,296			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		1,601,119	0	1,601,119			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	649,953	0	649,953	18,260.00	35.59	26.00
27.00	Administrative & General	5.00	1,704,869	0	1,704,869	52,977.00	32.18	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2017 1:49 pm

		Worksheet A Line Number	Amount Reported	Reclassification 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.)		286,471	0	286,471	5,186.00	55.24	28.00
29.00	Maintenance & Repairs	6.00	510,731	0	510,731	16,424.00	31.10	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	452,881	0	452,881	35,848.00	12.63	32.00
33.00	Housekeeping under contract (see instructions)		63,095	0	63,095	4,790.00	13.17	33.00
34.00	Dietary	10.00	371,606	0	371,606	24,232.00	15.34	34.00
35.00	Dietary under contract (see instructions)		2,464	0	2,464	181.00	13.61	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	884,139	0	884,139	21,064.00	41.97	38.00
39.00	Central Services and Supply	14.00	149,586	0	149,586	8,824.00	16.95	39.00
40.00	Pharmacy	15.00	900,624	0	900,624	19,519.00	46.14	40.00
41.00	Medical Records & Medical Records Library	16.00	192,806	0	192,806	4,592.00	41.99	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2017 1:49 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		22,188,570	0	22,188,570	706,676.00	31.40	1.00
2.00	Excluded area salaries (see instructions)		441,808	0	441,808	1,676.00	263.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)		21,746,762	0	21,746,762	705,000.00	30.85	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,392,008	0	5,392,008	185,490.00	29.07	4.00
5.00	Subtotal wage-related costs (see inst.)		6,215,857	0	6,215,857	0.00	28.58	5.00
6.00	Total (sum of lines 3 thru 5)		33,354,627	0	33,354,627	890,490.00	37.46	6.00
7.00	Total overhead cost (see instructions)		6,169,225	0	6,169,225	211,897.00	29.11	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2017 1:49 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	425,748	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,800	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	522,749	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,534,231	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	195,700	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,427	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)	130,730	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	400,521	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,490,970	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-2,842	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,710,034	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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2017 1:49 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			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			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/30/2017 1:49 pm

		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)	0.265602	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,891,860	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	28,861,189	6.00
7.00	Medicaid cost (line 1 times line 6)	7,665,590	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)	4,773,730	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)	4,773,730	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	63,532	4,261,157	4,324,689	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	16,874	1,131,772	1,148,646	21.00
22.00	Partial payment by patients approved for charity care	1,600	176,700	178,300	22.00
23.00	Cost of charity care (line 21 minus line 22)	15,274	955,072	970,346	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?		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)	5,748,900	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	152,170	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,596,730	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,486,503	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,456,849	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,230,579	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,990,019	4,990,019	-281,854	4,708,165	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	649,953	5,103,796	5,753,749	142,115	5,895,864	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,704,869	12,212,176	13,917,045	-195,317	13,721,728	5.00
6.00	00600	MAINTENANCE & REPAIRS	510,731	1,838,512	2,349,243	0	2,349,243	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,094	76,094	0	76,094	8.00
9.00	00900	HOUSEKEEPING	452,881	230,000	682,881	0	682,881	9.00
10.00	01000	DIETARY	371,606	268,838	640,444	-24	640,420	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	884,139	76,588	960,727	-22,217	938,510	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	149,586	478,801	628,387	-33,668	594,719	14.00
15.00	01500	PHARMACY	900,624	2,192,794	3,093,418	-1,709,959	1,383,459	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	192,806	1,567,414	1,760,220	0	1,760,220	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,262,630	1,578,047	4,840,677	-46,046	4,794,631	30.00
31.00	03100	INTENSIVE CARE UNIT	1,009,385	154,887	1,164,272	-37,650	1,126,622	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,657,225	7,265,827	9,923,052	-5,412,581	4,510,471	50.00
51.00	05100	RECOVERY ROOM	1,159,600	219,432	1,379,032	-87,837	1,291,195	51.00
53.00	05300	ANESTHESIOLOGY	31,514	634,461	665,975	-94,606	571,369	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,988,286	821,118	2,809,404	-271,005	2,538,399	54.00
57.00	05700	CT SCAN	450,308	621,004	1,071,312	-2,914	1,068,398	57.00
58.00	05800	MRI	289,714	731,614	1,021,328	-811	1,020,517	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,147,361	2,010,524	3,157,885	-1,835,754	1,322,131	59.00
60.00	06000	LABORATORY	0	2,788,911	2,788,911	0	2,788,911	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	553,982	86,765	640,747	-19,088	621,659	65.00
66.00	06600	PHYSICAL THERAPY	161,215	13,818	175,033	-13	175,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,211	72	19,283	0	19,283	68.00
69.00	06900	ELECTROCARDIOLOGY	250,184	23,947	274,131	-656	273,475	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	511,527	885,306	1,396,833	-62	1,396,771	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,661,214	2,661,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,969,679	4,969,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,004,075	2,004,075	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	144,890	10,006	154,896	0	154,896	76.01
76.02	03952	WOUND CARE	107,751	42,486	150,237	-16,112	134,125	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	338,141	292,939	631,080	-18,123	612,957	90.02
91.00	09100	EMERGENCY	1,494,613	1,219,504	2,714,117	-25,832	2,688,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-335,056	-335,056	335,056	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,394,732	48,100,644	69,495,376	10	69,495,386	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	441,808	32,825	474,633	-10	474,623	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	21,836,540	48,133,469	69,970,009	0	69,970,009	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,001,577	7,709,742		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-59,090	5,836,774		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,664,234	12,057,494		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,349,243		6.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,094		8.00
9.00	00900	HOUSEKEEPING	0	682,881		9.00
10.00	01000	DIETARY	0	640,420		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	938,510		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-308,424	286,295		14.00
15.00	01500	PHARMACY	36,034	1,419,493		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-729,042	1,031,178		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,252,008	3,542,623		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,126,622		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-446,144	4,064,327		50.00
51.00	05100	RECOVERY ROOM	0	1,291,195		51.00
53.00	05300	ANESTHESIOLOGY	0	571,369		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,620	2,536,779		54.00
57.00	05700	CT SCAN	-5,109	1,063,289		57.00
58.00	05800	MRI	-25,118	995,399		58.00
59.00	05900	CARDIAC CATHETERIZATION	-483,752	838,379		59.00
60.00	06000	LABORATORY	-6,911	2,782,000		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	621,659		65.00
66.00	06600	PHYSICAL THERAPY	0	175,020		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,283		68.00
69.00	06900	ELECTROCARDIOLOGY	0	273,475		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-6,888	1,389,883		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,661,214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,969,679		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,004,075		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	-3,835	151,061		76.01
76.02	03952	WOUND CARE	0	134,125		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	CLINIC	-7,600	605,357		90.02
91.00	09100	EMERGENCY	-747,372	1,940,913		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,709,536	66,785,850		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	474,623		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,709,536	67,260,473		200.00

RECLASSIFICATIONS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 1:49 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	142,115		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,202		2.00
	0		0	195,317		
	B - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	335,056		1.00
	0		0	335,056		
	C - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,004,075		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
	0		0	2,004,075		
	D - MED SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,661,744		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
	0		0	2,661,744		
	E - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,969,679		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	4,969,679		
500.00	Grand Total: Increases		0	10,165,871		500.00

RECLASSIFICATIONS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 1:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	195,317	0		1.00
2.00		0.00	0	0	9		2.00
	0		0	195,317			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	335,056	11		1.00
	0		0	335,056			
	C - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	1,709,959	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	20	0		2.00
3.00	OPERATING ROOM	50.00	0	1,995	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	28,212	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	254,455	0		5.00
6.00	CT SCAN	57.00	0	121	0		6.00
7.00	CLINIC	90.02	0	2,618	0		7.00
8.00	DIETARY	10.00	0	24	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	501	0		9.00
10.00	WOUND CARE	76.02	0	5,685	0		10.00
11.00	EMERGENCY	91.00	0	485	0		11.00
	0		0	2,004,075			
	D - MED SUPPLIES EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	33,668	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	13	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	46,046	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	34,227	0		4.00
5.00	OPERATING ROOM	50.00	0	1,771,639	0		5.00
6.00	RECOVERY ROOM	51.00	0	87,837	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	66,394	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,550	0		8.00
9.00	CT SCAN	57.00	0	2,793	0		9.00
10.00	MRI	58.00	0	811	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	520,679	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	19,088	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	656	0		13.00
14.00	WOUND CARE	76.02	0	10,427	0		14.00
15.00	CLINIC	90.02	0	15,505	0		15.00
16.00	EMERGENCY	91.00	0	25,347	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10	0		17.00
18.00	NURSING ADMINISTRATION	13.00	0	9,992	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	62	0		19.00
	0		0	2,661,744			
	E - IMPLANTABLE DEVICES						
1.00	INTENSIVE CARE UNIT	31.00	0	3,403	0		1.00
2.00	OPERATING ROOM	50.00	0	3,638,947	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	12,225	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	1,314,574	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	530	0		5.00
	0		0	4,969,679			
500.00	Grand Total: Decreases		0	10,165,871			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,869,989	0	0	0	0	1.00
2.00	Land Improvements	973,559	1,665,317	0	1,665,317	0	2.00
3.00	Buildings and Fixtures	26,805,106	22,946,674	0	22,946,674	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,601,229	40,194,485	0	40,194,485	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,249,883	64,806,476	0	64,806,476	0	8.00
9.00	Reconciling Items	-52,038,231	0	0	0	-42,005,754	9.00
10.00	Total (line 8 minus line 9)	112,288,114	64,806,476	0	64,806,476	42,005,754	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,869,989	0	1.00
2.00	Land Improvements	2,638,876	0	2.00
3.00	Buildings and Fixtures	49,751,780	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	64,795,714	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	125,056,359	0	8.00
9.00	Reconciling Items	-10,032,477	0	9.00
10.00	Total (line 8 minus line 9)	135,088,836	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2017 1:49 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,990,019	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)	4,990,019	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	4,990,019	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	4,990,019	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2017 1:49 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	4,708,165	0	4,708,165	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	4,708,165	0	4,708,165	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	6,090,414	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	6,090,414	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	1,619,328	0	0	0	7,709,742	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,619,328	0	0	0	7,709,742	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 1:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-26,563	CAP REL COSTS-BLDG & FIXT	1.00	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-358,096	ADMINISTRATIVE & GENERAL	5.00	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	-2,953,597			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	942,047			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	B	-1,325	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROPERTY TAXES (51009800)	A	721,259	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADVERTISING (41860XXX)	A	-17,896	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 1:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	RENTAL INCOME	B	-423,017	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS - OTHER OPERATING	B	-218	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DISCOUNTS/REBATES	B	-913	CARDIAC CATHETERIZATION	59.00	0	33.04
33.05	HAF ASSESSMENT FEES	A	-462,925	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENSION	A	-59,090	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	MEDICAL STAFF FEES	B	-36,583	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	INTEREST INCOME - OTHER	B	-1	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-1,620	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	LOBBYING	A	-771	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PROPERTY TAXES (51009800)	A	-5,109	CT SCAN	57.00	0	33.11
33.12	PROPERTY TAXES (51009800)	A	-25,118	MRI	58.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,709,536				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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 1:49 pm

	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	1.00	CAP REL COSTS-BLDG & FIXT	FA-INT	1,954,384	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	1,073,756	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	8,187,424	9,272,085	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	0	308,424	4.00
4.01	15.00	PHARMACY	FA-COEP	83,626	47,592	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HIM	825,339	1,554,381	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,124,529	11,182,482	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		
	Symbol (1)	Name	Percentage of Ownership	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	FRANCISCAN ALLI	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:					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: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/30/2017 1:49 pm

	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	1,954,384	11		1.00
2.00	1,073,756	9		2.00
3.00	-1,084,661	0		3.00
4.00	-308,424	0		4.00
4.01	36,034	0		4.01
4.02	-729,042	0		4.02
5.00	942,047			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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2017 1:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,252,008	1,252,008	0	0	0	1.00
2.00	50.00	OPERATING ROOM	431,000	431,000	0	0	0	2.00
3.00	50.00	OPERATING ROOM	9,500	0	9,500	200,300	76	3.00
4.00	50.00	OPERATING ROOM	36,075	75	36,000	200,300	240	4.00
5.00	59.00	CARDIAC CATHETERIZATION	236,620	138,069	98,551	200,300	788	5.00
6.00	59.00	CARDIAC CATHETERIZATION	322,102	322,102	0	0	0	6.00
7.00	60.00	LABORATORY	24,148	0	24,148	200,300	179	7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	30,000	0	30,000	200,300	240	8.00
9.00	76.01	CARDIAC AND PULMONARY REHAB	3,835	3,835	0	0	0	9.00
10.00	90.02	CLINIC	7,600	7,600	0	0	0	10.00
11.00	91.00	EMERGENCY	747,372	747,372	0	0	0	11.00
200.00			3,100,260	2,902,061	198,199		1,523	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	7,319	366	0	0	0	3.00
4.00	50.00	OPERATING ROOM	23,112	1,156	0	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	75,883	3,794	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	17,237	862	0	0	0	7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	23,112	1,156	0	0	0	8.00
9.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	9.00
10.00	90.02	CLINIC	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			146,663	7,334	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,252,008		1.00
2.00	50.00	OPERATING ROOM	0	0	0	431,000		2.00
3.00	50.00	OPERATING ROOM	0	7,319	2,181	2,181		3.00
4.00	50.00	OPERATING ROOM	0	23,112	12,888	12,963		4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	75,883	22,668	160,737		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	322,102		6.00
7.00	60.00	LABORATORY	0	17,237	6,911	6,911		7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	0	23,112	6,888	6,888		8.00
9.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	3,835		9.00
10.00	90.02	CLINIC	0	0	0	7,600		10.00
11.00	91.00	EMERGENCY	0	0	0	747,372		11.00
200.00			0	146,663	51,536	2,953,597		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,709,742	7,709,742				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,836,774	229,372	0	6,066,146		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,057,494	457,939	0	488,138	13,003,571	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,349,243	0	0	146,232	2,495,475	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,094	0	0	0	76,094	8.00
9.00	00900	HOUSEKEEPING	682,881	0	0	129,669	812,550	9.00
10.00	01000	DIETARY	640,420	239,126	0	106,398	985,944	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	938,510	0	0	253,147	1,191,657	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	286,295	0	0	42,829	329,124	14.00
15.00	01500	PHARMACY	1,419,493	307,706	0	257,867	1,985,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,031,178	80,245	0	55,204	1,166,627	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,542,623	1,004,469	0	934,160	5,481,252	30.00
31.00	03100	INTENSIVE CARE UNIT	1,126,622	637,032	0	289,007	2,052,661	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,064,327	3,413,220	0	760,817	8,238,364	50.00
51.00	05100	RECOVERY ROOM	1,291,195	637,032	0	332,017	2,260,244	51.00
53.00	05300	ANESTHESIOLOGY	571,369	0	0	9,023	580,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,536,779	0	0	569,286	3,106,065	54.00
57.00	05700	CT SCAN	1,063,289	0	0	128,932	1,192,221	57.00
58.00	05800	MRI	995,399	0	0	82,951	1,078,350	58.00
59.00	05900	CARDIAC CATHETERIZATION	838,379	0	0	328,512	1,166,891	59.00
60.00	06000	LABORATORY	2,782,000	284,377	0	0	3,066,377	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	121,373	0	0	121,373	64.01
65.00	06500	RESPIRATORY THERAPY	621,659	141,685	0	158,616	921,960	65.00
66.00	06600	PHYSICAL THERAPY	175,020	0	0	46,159	221,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,283	0	0	5,500	24,783	68.00
69.00	06900	ELECTROCARDIOLOGY	273,475	0	0	71,633	345,108	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,389,883	156,166	0	146,460	1,692,509	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,661,214	0	0	0	2,661,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,969,679	0	0	0	4,969,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,004,075	0	0	0	2,004,075	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	151,061	0	0	41,485	192,546	76.01
76.02	03952	WOUND CARE	134,125	0	0	30,851	164,976	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	605,357	0	0	96,817	702,174	90.02
91.00	09100	EMERGENCY	1,940,913	0	0	427,938	2,368,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,785,850	7,709,742	0	5,939,648	66,659,352	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	474,623	0	0	126,498	601,121	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,260,473	7,709,742	0	6,066,146	67,260,473	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,003,571					5.00
6.00	00600	MAINTENANCE & REPAIRS	598,083	3,093,558				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,237	0	0	94,331		8.00
9.00	00900	HOUSEKEEPING	194,741	0	0	251	1,007,542	9.00
10.00	01000	DIETARY	236,298	105,341	0	0	34,309	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	285,601	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,880	0	0	0	0	14.00
15.00	01500	PHARMACY	475,755	135,552	0	0	44,148	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	279,602	35,350	0	0	11,513	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,313,675	442,494	0	40,145	144,116	30.00
31.00	03100	INTENSIVE CARE UNIT	491,955	280,628	0	0	91,398	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,974,448	1,503,611	0	53,935	489,711	50.00
51.00	05100	RECOVERY ROOM	541,706	280,628	0	0	91,398	51.00
53.00	05300	ANESTHESIOLOGY	139,101	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	744,421	0	0	0	0	54.00
57.00	05700	CT SCAN	285,736	0	0	0	0	57.00
58.00	05800	MRI	258,445	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	279,665	0	0	0	0	59.00
60.00	06000	LABORATORY	734,909	125,275	0	0	40,801	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	29,089	53,468	0	0	17,414	64.01
65.00	06500	RESPIRATORY THERAPY	220,963	62,416	0	0	20,328	65.00
66.00	06600	PHYSICAL THERAPY	53,009	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,940	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	82,711	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	405,639	68,795	0	0	22,406	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	637,805	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,191,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,311	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	46,147	0	0	0	0	76.01
76.02	03952	WOUND CARE	39,539	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	168,288	0	0	0	0	90.02
91.00	09100	EMERGENCY	567,735	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,859,502	3,093,558	0	94,331	1,007,542	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	144,069	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,003,571	3,093,558	0	94,331	1,007,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,361,892					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,477,258		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,439	409,443	14.00
15.00	01500	PHARMACY	0	0	0	3,238	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,039,531	0	0	300,596	0	30.00
31.00	03100	INTENSIVE CARE UNIT	322,361	0	0	100,559	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	275,052	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	62,602	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	181,689	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
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	409,443	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	385,145	0	90.02
91.00	09100	EMERGENCY	0	0	0	166,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,361,892	0	0	1,477,258	409,443	118.00
		NONREIMBURSABLE COST CENTERS						
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
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)	1,361,892	0	0	1,477,258	409,443	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,643,759					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,493,092				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	88,481	8,850,290	0	8,850,290	30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,511	3,368,073	0	3,368,073	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	245,780	12,780,901	0	12,780,901	50.00
51.00	05100	RECOVERY ROOM	0	35,441	3,272,019	0	3,272,019	51.00
53.00	05300	ANESTHESIOLOGY	0	61,186	780,679	0	780,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	149,166	3,999,652	0	3,999,652	54.00
57.00	05700	CT SCAN	0	139,472	1,617,429	0	1,617,429	57.00
58.00	05800	MRI	0	105,868	1,442,663	0	1,442,663	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	100,840	1,729,085	0	1,729,085	59.00
60.00	06000	LABORATORY	0	96,894	4,064,256	0	4,064,256	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	221,344	0	221,344	64.01
65.00	06500	RESPIRATORY THERAPY	0	21,377	1,247,044	0	1,247,044	65.00
66.00	06600	PHYSICAL THERAPY	0	5,197	279,385	0	279,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	221	30,944	0	30,944	68.00
69.00	06900	ELECTROCARDIOLOGY	0	44,794	472,613	0	472,613	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	32,228	2,221,577	0	2,221,577	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	52,401	3,760,863	0	3,760,863	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	74,073	6,234,820	0	6,234,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,643,759	93,749	5,221,894	0	5,221,894	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	1,195	239,888	0	239,888	76.01
76.02	03952	WOUND CARE	0	1,880	206,395	0	206,395	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	36,789	1,292,396	0	1,292,396	90.02
91.00	09100	EMERGENCY	0	77,549	3,181,073	0	3,181,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,643,759	1,493,092	66,515,283	0	66,515,283	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	745,190	0	745,190	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,643,759	1,493,092	67,260,473	0	67,260,473	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	229,372	0	229,372	229,372	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	457,939	0	457,939	18,457	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	5,529	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	4,903	9.00
10.00	01000	DIETARY	0	239,126	0	239,126	4,023	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,619	14.00
15.00	01500	PHARMACY	0	307,706	0	307,706	9,750	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,245	0	80,245	2,087	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,004,469	0	1,004,469	35,328	30.00
31.00	03100	INTENSIVE CARE UNIT	0	637,032	0	637,032	10,928	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,413,220	0	3,413,220	28,767	50.00
51.00	05100	RECOVERY ROOM	0	637,032	0	637,032	12,554	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	21,525	54.00
57.00	05700	CT SCAN	0	0	0	0	4,875	57.00
58.00	05800	MRI	0	0	0	0	3,136	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	12,421	59.00
60.00	06000	LABORATORY	0	284,377	0	284,377	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	121,373	0	121,373	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	141,685	0	141,685	5,997	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	208	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,708	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	156,166	0	156,166	5,538	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	1,569	76.01
76.02	03952	WOUND CARE	0	0	0	0	1,167	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	3,661	90.02
91.00	09100	EMERGENCY	0	0	0	0	16,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,709,742	0	7,709,742	224,589	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4,783	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	7,709,742	0	7,709,742	229,372	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	476,396					5.00
6.00	00600	MAINTENANCE & REPAIRS	21,910	27,439				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	668	0	0	668		8.00
9.00	00900	HOUSEKEEPING	7,134	0	0	2	12,039	9.00
10.00	01000	DIETARY	8,657	934	0	0	410	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,463	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,890	0	0	0	0	14.00
15.00	01500	PHARMACY	17,429	1,202	0	0	528	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,243	314	0	0	138	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,125	3,925	0	284	1,722	30.00
31.00	03100	INTENSIVE CARE UNIT	18,022	2,489	0	0	1,092	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,352	13,337	0	382	5,850	50.00
51.00	05100	RECOVERY ROOM	19,845	2,489	0	0	1,092	51.00
53.00	05300	ANESTHESIOLOGY	5,096	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,271	0	0	0	0	54.00
57.00	05700	CT SCAN	10,468	0	0	0	0	57.00
58.00	05800	MRI	9,468	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,245	0	0	0	0	59.00
60.00	06000	LABORATORY	26,923	1,111	0	0	488	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,066	474	0	0	208	64.01
65.00	06500	RESPIRATORY THERAPY	8,095	554	0	0	243	65.00
66.00	06600	PHYSICAL THERAPY	1,942	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	218	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,030	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,860	610	0	0	268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,365	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,634	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,596	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1,691	0	0	0	0	76.01
76.02	03952	WOUND CARE	1,448	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	6,165	0	0	0	0	90.02
91.00	09100	EMERGENCY	20,799	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	471,118	27,439	0	668	12,039	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,278	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	476,396	27,439	0	668	12,039	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	253,150					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	20,035		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	20	4,529	14.00
15.00	01500	PHARMACY	0	0	0	44	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	193,229	0	0	4,077	0	30.00
31.00	03100	INTENSIVE CARE UNIT	59,921	0	0	1,364	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,730	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	849	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,464	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
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,529	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	5,223	0	90.02
91.00	09100	EMERGENCY	0	0	0	2,264	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	253,150	0	0	20,035	4,529	118.00
		NONREIMBURSABLE COST CENTERS						
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
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)	253,150	0	0	20,035	4,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	336,659					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	93,027				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,506	1,296,665	0	1,296,665	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,774	732,622	0	732,622	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,413	3,553,051	0	3,553,051	50.00
51.00	05100	RECOVERY ROOM	0	2,205	676,066	0	676,066	51.00
53.00	05300	ANESTHESIOLOGY	0	3,807	9,244	0	9,244	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,282	58,078	0	58,078	54.00
57.00	05700	CT SCAN	0	8,679	24,022	0	24,022	57.00
58.00	05800	MRI	0	6,588	19,192	0	19,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,275	31,405	0	31,405	59.00
60.00	06000	LABORATORY	0	6,029	318,928	0	318,928	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	123,121	0	123,121	64.01
65.00	06500	RESPIRATORY THERAPY	0	1,330	157,904	0	157,904	65.00
66.00	06600	PHYSICAL THERAPY	0	323	4,010	0	4,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	14	440	0	440	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,787	8,525	0	8,525	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,005	179,447	0	179,447	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,261	31,155	0	31,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,609	48,243	0	48,243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	336,659	5,834	360,089	0	360,089	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	74	3,334	0	3,334	76.01
76.02	03952	WOUND CARE	0	117	2,732	0	2,732	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	2,289	17,338	0	17,338	90.02
91.00	09100	EMERGENCY	0	4,826	44,070	0	44,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	336,659	93,027	7,699,681	0	7,699,681	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,061	0	10,061	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	336,659	93,027	7,709,742	0	7,709,742	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	76,670					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		76,670				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,281	2,281	21,186,587			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,554	4,554	1,704,869	-13,003,571	54,256,902	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	510,731	0	2,495,475	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	76,094	8.00
9.00	00900	HOUSEKEEPING	0	0	452,881	0	812,550	9.00
10.00	01000	DIETARY	2,378	2,378	371,606	0	985,944	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	884,139	0	1,191,657	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	149,586	0	329,124	14.00
15.00	01500	PHARMACY	3,060	3,060	900,624	0	1,985,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	798	798	192,806	0	1,166,627	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,989	9,989	3,262,630	0	5,481,252	30.00
31.00	03100	INTENSIVE CARE UNIT	6,335	6,335	1,009,385	0	2,052,661	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,943	33,943	2,657,225	0	8,238,364	50.00
51.00	05100	RECOVERY ROOM	6,335	6,335	1,159,600	0	2,260,244	51.00
53.00	05300	ANESTHESIOLOGY	0	0	31,514	0	580,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,988,286	0	3,106,065	54.00
57.00	05700	CT SCAN	0	0	450,308	0	1,192,221	57.00
58.00	05800	MRI	0	0	289,714	0	1,078,350	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,147,361	0	1,166,891	59.00
60.00	06000	LABORATORY	2,828	2,828	0	0	3,066,377	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,207	1,207	0	0	121,373	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	553,982	0	921,960	65.00
66.00	06600	PHYSICAL THERAPY	0	0	161,215	0	221,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	19,211	0	24,783	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	250,184	0	345,108	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,553	1,553	511,527	0	1,692,509	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,661,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,969,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,004,075	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	144,890	0	192,546	76.01
76.02	03952	WOUND CARE	0	0	107,751	0	164,976	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	338,141	0	702,174	90.02
91.00	09100	EMERGENCY	0	0	1,494,613	0	2,368,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,670	76,670	20,744,779	-13,003,571	53,655,781	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	441,808	0	601,121	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,709,742	0	6,066,146		13,003,571	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	100.557480	0.000000	0.286320		0.239667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			229,372		476,396	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.010826		0.008780	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	69,835					6.00
7.00	00700	OPERATION OF PLANT	0	69,835				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	204,646			8.00
9.00	00900	HOUSEKEEPING	0	0	545	69,835		9.00
10.00	01000	DIETARY	2,378	2,378	0	2,378	31,356	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,060	3,060	0	3,060	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	798	798	0	798	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,989	9,989	87,092	9,989	23,934	30.00
31.00	03100	INTENSIVE CARE UNIT	6,335	6,335	0	6,335	7,422	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,943	33,943	117,009	33,943	0	50.00
51.00	05100	RECOVERY ROOM	6,335	6,335	0	6,335	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,828	2,828	0	2,828	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,207	1,207	0	1,207	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	0	1,409	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	1,553	1,553	0	1,553	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,835	69,835	204,646	69,835	31,356	118.00
		NONREIMBURSABLE COST CENTERS						
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
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)	3,093,558	0	94,331	1,007,542	1,361,892	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.298103	0.000000	0.460947	14.427465	43.433219	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,439	0	668	12,039	253,150	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.392912	0.000000	0.003264	0.172392	8.073415	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	CAFETERIA (NUMBER HOUSED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,212			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8	100		14.00
15.00	01500	PHARMACY	0	0	18	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,671	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	559	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,529	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	348	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,010	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
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	100	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	100	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	2,141	0	0	90.02
91.00	09100	EMERGENCY	0	0	928	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	8,212	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
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
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	0	1,477,258	409,443	2,643,759	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	179.890161	4,094.430000	26,437.590000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	20,035	4,529	336,659	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	2.439722	45.290000	3,366.590000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 1:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
			16.00				
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	250,432,018				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,840,797				30.00
31.00	03100	INTENSIVE CARE UNIT	4,782,058				31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	41,222,169				50.00
51.00	05100	RECOVERY ROOM	5,944,494				51.00
53.00	05300	ANESTHESIOLOGY	10,262,620				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,019,457				54.00
57.00	05700	CT SCAN	23,393,415				57.00
58.00	05800	MRI	17,757,134				58.00
59.00	05900	CARDIAC CATHETERIZATION	16,913,862				59.00
60.00	06000	LABORATORY	16,251,890				60.00
64.00	06400	INTRAVENOUS THERAPY	0				64.00
64.01	06401	INTRAVENOUS THERAPY	0				64.01
65.00	06500	RESPIRATORY THERAPY	3,585,497				65.00
66.00	06600	PHYSICAL THERAPY	871,671				66.00
67.00	06700	OCCUPATIONAL THERAPY	0				67.00
68.00	06800	SPEECH PATHOLOGY	37,021				68.00
69.00	06900	ELECTROCARDIOLOGY	7,513,177				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,405,594				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,789,102				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,424,201				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,724,414				73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0				76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	200,357				76.01
76.02	03952	WOUND CARE	315,344				76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0				90.00
90.01	09001	CLINIC	0				90.01
90.02	09002	CLINIC	6,170,539				90.02
91.00	09100	EMERGENCY	13,007,205				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	250,432,018				118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0				192.00
193.00	19300	NONPAID WORKERS	0				193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,493,092				202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005962				203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,027				204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000371				205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 1:49 pm

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	8,850,290		8,850,290	0	8,850,290	30.00
31.00	03100	INTENSIVE CARE UNIT	3,368,073		3,368,073	0	3,368,073	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,780,901		12,780,901	15,069	12,795,970	50.00
51.00	05100	RECOVERY ROOM	3,272,019		3,272,019	0	3,272,019	51.00
53.00	05300	ANESTHESIOLOGY	780,679		780,679	0	780,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,999,652		3,999,652	0	3,999,652	54.00
57.00	05700	CT SCAN	1,617,429		1,617,429	0	1,617,429	57.00
58.00	05800	MRI	1,442,663		1,442,663	0	1,442,663	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,729,085		1,729,085	22,668	1,751,753	59.00
60.00	06000	LABORATORY	4,064,256		4,064,256	6,911	4,071,167	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	221,344		221,344	0	221,344	64.01
65.00	06500	RESPIRATORY THERAPY	1,247,044	0	1,247,044	0	1,247,044	65.00
66.00	06600	PHYSICAL THERAPY	279,385	0	279,385	0	279,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,944	0	30,944	0	30,944	68.00
69.00	06900	ELECTROCARDIOLOGY	472,613		472,613	0	472,613	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,221,577		2,221,577	6,888	2,228,465	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,760,863		3,760,863	0	3,760,863	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,234,820		6,234,820	0	6,234,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,221,894		5,221,894	0	5,221,894	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	239,888		239,888	0	239,888	76.01
76.02	03952	WOUND CARE	206,395		206,395	0	206,395	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	0		0	0	0	90.01
90.02	09002	CLINIC	1,292,396		1,292,396	0	1,292,396	90.02
91.00	09100	EMERGENCY	3,181,073		3,181,073	0	3,181,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,539,621		2,539,621		2,539,621	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,054,904	0	69,054,904	51,536	69,106,440	200.00
201.00		Less Observation Beds	2,539,621		2,539,621		2,539,621	201.00
202.00		Total (see instructions)	66,515,283	0	66,515,283	51,536	66,566,819	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,465,664		10,465,664			30.00
31.00	03100	INTENSIVE CARE UNIT	4,782,058		4,782,058			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,868,447	36,353,722	41,222,169	0.310049	0.000000	50.00
51.00	05100	RECOVERY ROOM	753,601	5,190,893	5,944,494	0.550429	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,541,515	8,721,105	10,262,620	0.076070	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,116,305	22,903,152	25,019,457	0.159862	0.000000	54.00
57.00	05700	CT SCAN	3,073,638	20,319,777	23,393,415	0.069140	0.000000	57.00
58.00	05800	MRI	1,023,330	16,733,804	17,757,134	0.081244	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,498,752	10,415,110	16,913,862	0.102229	0.000000	59.00
60.00	06000	LABORATORY	6,199,849	10,052,041	16,251,890	0.250079	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	3,141,574	443,923	3,585,497	0.347802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	763,488	108,183	871,671	0.320517	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	34,151	2,870	37,021	0.835850	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,635,398	5,877,779	7,513,177	0.062905	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,405,594	5,405,594	0.410977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,451,309	6,337,793	8,789,102	0.427901	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,341,815	7,082,386	12,424,201	0.501829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,358,267	7,366,147	15,724,414	0.332088	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	113	200,244	200,357	1.197303	0.000000	76.01
76.02	03952	WOUND CARE	2,151	313,193	315,344	0.654507	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	6,170,539	6,170,539	0.209446	0.000000	90.02
91.00	09100	EMERGENCY	3,005,879	10,001,326	13,007,205	0.244562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	653,798	3,721,335	4,375,133	0.580467	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	66,711,102	183,720,916	250,432,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,711,102	183,720,916	250,432,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.310415		50.00
51.00	05100	RECOVERY ROOM	0.550429		51.00
53.00	05300	ANESTHESIOLOGY	0.076070		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159862		54.00
57.00	05700	CT SCAN	0.069140		57.00
58.00	05800	MRI	0.081244		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103569		59.00
60.00	06000	LABORATORY	0.250504		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000		64.01
65.00	06500	RESPIRATORY THERAPY	0.347802		65.00
66.00	06600	PHYSICAL THERAPY	0.320517		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.835850		68.00
69.00	06900	ELECTROCARDIOLOGY	0.062905		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.412252		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427901		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501829		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332088		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1.197303		76.01
76.02	03952	WOUND CARE	0.654507		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC	0.000000		90.01
90.02	09002	CLINIC	0.209446		90.02
91.00	09100	EMERGENCY	0.244562		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580467		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,850,290		8,850,290	0	8,850,290	30.00
31.00	03100	INTENSIVE CARE UNIT	3,368,073		3,368,073	0	3,368,073	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,780,901		12,780,901	15,069	12,795,970	50.00
51.00	05100	RECOVERY ROOM	3,272,019		3,272,019	0	3,272,019	51.00
53.00	05300	ANESTHESIOLOGY	780,679		780,679	0	780,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,999,652		3,999,652	0	3,999,652	54.00
57.00	05700	CT SCAN	1,617,429		1,617,429	0	1,617,429	57.00
58.00	05800	MRI	1,442,663		1,442,663	0	1,442,663	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,729,085		1,729,085	22,668	1,751,753	59.00
60.00	06000	LABORATORY	4,064,256		4,064,256	6,911	4,071,167	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	221,344		221,344	0	221,344	64.01
65.00	06500	RESPIRATORY THERAPY	1,247,044	0	1,247,044	0	1,247,044	65.00
66.00	06600	PHYSICAL THERAPY	279,385	0	279,385	0	279,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,944	0	30,944	0	30,944	68.00
69.00	06900	ELECTROCARDIOLOGY	472,613		472,613	0	472,613	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,221,577		2,221,577	6,888	2,228,465	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,760,863		3,760,863	0	3,760,863	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,234,820		6,234,820	0	6,234,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,221,894		5,221,894	0	5,221,894	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	239,888		239,888	0	239,888	76.01
76.02	03952	WOUND CARE	206,395		206,395	0	206,395	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	0		0	0	0	90.01
90.02	09002	CLINIC	1,292,396		1,292,396	0	1,292,396	90.02
91.00	09100	EMERGENCY	3,181,073		3,181,073	0	3,181,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,539,621		2,539,621		2,539,621	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,054,904	0	69,054,904	51,536	69,106,440	200.00
201.00		Less Observation Beds	2,539,621		2,539,621		2,539,621	201.00
202.00		Total (see instructions)	66,515,283	0	66,515,283	51,536	66,566,819	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,465,664		10,465,664			30.00
31.00	03100	INTENSIVE CARE UNIT	4,782,058		4,782,058			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,868,447	36,353,722	41,222,169	0.310049	0.000000	50.00
51.00	05100	RECOVERY ROOM	753,601	5,190,893	5,944,494	0.550429	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,541,515	8,721,105	10,262,620	0.076070	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,116,305	22,903,152	25,019,457	0.159862	0.000000	54.00
57.00	05700	CT SCAN	3,073,638	20,319,777	23,393,415	0.069140	0.000000	57.00
58.00	05800	MRI	1,023,330	16,733,804	17,757,134	0.081244	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,498,752	10,415,110	16,913,862	0.102229	0.000000	59.00
60.00	06000	LABORATORY	6,199,849	10,052,041	16,251,890	0.250079	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	3,141,574	443,923	3,585,497	0.347802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	763,488	108,183	871,671	0.320517	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	34,151	2,870	37,021	0.835850	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,635,398	5,877,779	7,513,177	0.062905	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,405,594	5,405,594	0.410977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,451,309	6,337,793	8,789,102	0.427901	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,341,815	7,082,386	12,424,201	0.501829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,358,267	7,366,147	15,724,414	0.332088	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	113	200,244	200,357	1.197303	0.000000	76.01
76.02	03952	WOUND CARE	2,151	313,193	315,344	0.654507	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	6,170,539	6,170,539	0.209446	0.000000	90.02
91.00	09100	EMERGENCY	3,005,879	10,001,326	13,007,205	0.244562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	653,798	3,721,335	4,375,133	0.580467	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	66,711,102	183,720,916	250,432,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,711,102	183,720,916	250,432,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.310415	50.00
51.00	05100	RECOVERY ROOM	0.550429	51.00
53.00	05300	ANESTHESIOLOGY	0.076070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159862	54.00
57.00	05700	CT SCAN	0.069140	57.00
58.00	05800	MRI	0.081244	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103569	59.00
60.00	06000	LABORATORY	0.250504	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0.347802	65.00
66.00	06600	PHYSICAL THERAPY	0.320517	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.835850	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062905	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.412252	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332088	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1.197303	76.01
76.02	03952	WOUND CARE	0.654507	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.000000	90.01
90.02	09002	CLINIC	0.209446	90.02
91.00	09100	EMERGENCY	0.244562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580467	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	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	12,780,901	3,553,051	9,227,850	0	0	50.00
51.00	05100	RECOVERY ROOM	3,272,019	676,066	2,595,953	0	0	51.00
53.00	05300	ANESTHESIOLOGY	780,679	9,244	771,435	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,999,652	58,078	3,941,574	0	0	54.00
57.00	05700	CT SCAN	1,617,429	24,022	1,593,407	0	0	57.00
58.00	05800	MRI	1,442,663	19,192	1,423,471	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,729,085	31,405	1,697,680	0	0	59.00
60.00	06000	LABORATORY	4,064,256	318,928	3,745,328	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	221,344	123,121	98,223	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,247,044	157,904	1,089,140	0	0	65.00
66.00	06600	PHYSICAL THERAPY	279,385	4,010	275,375	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,944	440	30,504	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	472,613	8,525	464,088	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,221,577	179,447	2,042,130	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,760,863	31,155	3,729,708	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,234,820	48,243	6,186,577	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,221,894	360,089	4,861,805	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	239,888	3,334	236,554	0	0	76.01
76.02	03952	WOUND CARE	206,395	2,732	203,663	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,292,396	17,338	1,275,058	0	0	90.02
91.00	09100	EMERGENCY	3,181,073	44,070	3,137,003	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,539,621	372,082	2,167,539	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	56,836,541	6,042,476	50,794,065	0	0	200.00
201.00		Less Observation Beds	2,539,621	372,082	2,167,539	0	0	201.00
202.00		Total (line 200 minus line 201)	54,296,920	5,670,394	48,626,526	0	0	202.00

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

Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		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	12,780,901	41,222,169	0.310049		50.00
51.00	05100	RECOVERY ROOM	3,272,019	5,944,494	0.550429		51.00
53.00	05300	ANESTHESIOLOGY	780,679	10,262,620	0.076070		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,999,652	25,019,457	0.159862		54.00
57.00	05700	CT SCAN	1,617,429	23,393,415	0.069140		57.00
58.00	05800	MRI	1,442,663	17,757,134	0.081244		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,729,085	16,913,862	0.102229		59.00
60.00	06000	LABORATORY	4,064,256	16,251,890	0.250079		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
64.01	06401	INTRAVENOUS THERAPY	221,344	0	0.000000		64.01
65.00	06500	RESPIRATORY THERAPY	1,247,044	3,585,497	0.347802		65.00
66.00	06600	PHYSICAL THERAPY	279,385	871,671	0.320517		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	30,944	37,021	0.835850		68.00
69.00	06900	ELECTROCARDIOLOGY	472,613	7,513,177	0.062905		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,221,577	5,405,594	0.410977		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,760,863	8,789,102	0.427901		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,234,820	12,424,201	0.501829		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,221,894	15,724,414	0.332088		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	239,888	200,357	1.197303		76.01
76.02	03952	WOUND CARE	206,395	315,344	0.654507		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	CLINIC	0	0	0.000000		90.01
90.02	09002	CLINIC	1,292,396	6,170,539	0.209446		90.02
91.00	09100	EMERGENCY	3,181,073	13,007,205	0.244562		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,539,621	4,375,133	0.580467		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	56,836,541	235,184,296			200.00
201.00		Less Observation Beds	2,539,621	0			201.00
202.00		Total (line 200 minus line 201)	54,296,920	235,184,296			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,296,665	0	1,296,665	8,538	151.87	30.00
31.00	INTENSIVE CARE UNIT	732,622		732,622	1,888	388.04	31.00
200.00	Total (lines 30-199)	2,029,287		2,029,287	10,426		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	3,208	487,199				30.00
31.00	INTENSIVE CARE UNIT	309	119,904				31.00
200.00	Total (lines 30-199)	3,517	607,103				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | 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	3,553,051	41,222,169	0.086193	489,871	42,223	50.00
51.00	05100	RECOVERY ROOM	676,066	5,944,494	0.113730	249,769	28,406	51.00
53.00	05300	ANESTHESIOLOGY	9,244	10,262,620	0.000901	488,961	441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,078	25,019,457	0.002321	903,036	2,096	54.00
57.00	05700	CT SCAN	24,022	23,393,415	0.001027	1,412,631	1,451	57.00
58.00	05800	MRI	19,192	17,757,134	0.001081	374,650	405	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,405	16,913,862	0.001857	4,177,707	7,758	59.00
60.00	06000	LABORATORY	318,928	16,251,890	0.019624	2,905,163	57,011	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	123,121	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	157,904	3,585,497	0.044040	1,631,829	71,866	65.00
66.00	06600	PHYSICAL THERAPY	4,010	871,671	0.004600	405,325	1,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	440	37,021	0.011885	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,525	7,513,177	0.001135	792,577	900	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179,447	5,405,594	0.033197	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,155	8,789,102	0.003545	980,596	3,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,243	12,424,201	0.003883	2,043,774	7,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360,089	15,724,414	0.022900	3,219,957	73,737	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	3,334	200,357	0.016640	0	0	76.01
76.02	03952	WOUND CARE	2,732	315,344	0.008664	1,706	15	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC	17,338	6,170,539	0.002810	0	0	90.02
91.00	09100	EMERGENCY	44,070	13,007,205	0.003388	1,275,229	4,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	372,082	4,375,133	0.085045	468,341	39,830	92.00
200.00		Total (lines 50-199)	6,042,476	235,184,296		21,821,122	343,735	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
200.00		Total (lines 30-199)	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	8,538	0.00	3,208	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,888	0.00	309	0		31.00
200.00		Total (lines 30-199)	10,426		3,517	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,222,169	0.000000	0.000000	489,871	50.00
51.00	05100	RECOVERY ROOM	0	5,944,494	0.000000	0.000000	249,769	51.00
53.00	05300	ANESTHESIOLOGY	0	10,262,620	0.000000	0.000000	488,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,019,457	0.000000	0.000000	903,036	54.00
57.00	05700	CT SCAN	0	23,393,415	0.000000	0.000000	1,412,631	57.00
58.00	05800	MRI	0	17,757,134	0.000000	0.000000	374,650	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,913,862	0.000000	0.000000	4,177,707	59.00
60.00	06000	LABORATORY	0	16,251,890	0.000000	0.000000	2,905,163	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	3,585,497	0.000000	0.000000	1,631,829	65.00
66.00	06600	PHYSICAL THERAPY	0	871,671	0.000000	0.000000	405,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,021	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,513,177	0.000000	0.000000	792,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,405,594	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,789,102	0.000000	0.000000	980,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,424,201	0.000000	0.000000	2,043,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,724,414	0.000000	0.000000	3,219,957	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	200,357	0.000000	0.000000	0	76.01
76.02	03952	WOUND CARE	0	315,344	0.000000	0.000000	1,706	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	6,170,539	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	13,007,205	0.000000	0.000000	1,275,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,375,133	0.000000	0.000000	468,341	92.00
200.00		Total (lines 50-199)	0	235,184,296			21,821,122	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | 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	8,969,143	0		50.00
51.00	05100	RECOVERY ROOM	0	1,084,111	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,799,319	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,044,296	0		54.00
57.00	05700	CT SCAN	0	5,672,695	0		57.00
58.00	05800	MRI	0	3,247,172	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,843,921	0		59.00
60.00	06000	LABORATORY	0	2,136,420	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	146,280	0		65.00
66.00	06600	PHYSICAL THERAPY	0	36,618	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	920	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,955,841	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,368,890	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,886,847	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,084,759	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,386,938	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0		76.01
76.02	03952	WOUND CARE	0	107,226	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
90.02	09002	CLINIC	0	2,665,594	0		90.02
91.00	09100	EMERGENCY	0	1,808,277	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	696,591	0		92.00
200.00		Total (lines 50-199)	0	48,941,858	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.310049	8,969,143	0	0	2,780,874	50.00
51.00	05100	RECOVERY ROOM	0.550429	1,084,111	0	0	596,726	51.00
53.00	05300	ANESTHESIOLOGY	0.076070	1,799,319	0	0	136,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159862	6,044,296	0	0	966,253	54.00
57.00	05700	CT SCAN	0.069140	5,672,695	0	0	392,210	57.00
58.00	05800	MRI	0.081244	3,247,172	0	0	263,813	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.102229	3,843,921	0	0	392,960	59.00
60.00	06000	LABORATORY	0.250079	2,136,420	35	0	534,274	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.347802	146,280	0	0	50,876	65.00
66.00	06600	PHYSICAL THERAPY	0.320517	36,618	0	0	11,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.835850	920	0	0	769	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062905	1,955,841	0	0	123,032	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.410977	1,368,890	0	0	562,582	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427901	1,886,847	0	0	807,384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501829	2,084,759	0	0	1,046,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332088	3,386,938	0	18,367	1,124,761	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1.197303	0	0	0	0	76.01
76.02	03952	WOUND CARE	0.654507	107,226	0	0	70,180	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.209446	2,665,594	0	0	558,298	90.02
91.00	09100	EMERGENCY	0.244562	1,808,277	0	0	442,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580467	696,591	0	0	404,348	92.00
200.00		Subtotal (see instructions)		48,941,858	35	18,367	11,266,380	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		48,941,858	35	18,367	11,266,380	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	9	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,099		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0		76.01
76.02	03952	WOUND CARE	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
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)	9	6,099		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	9	6,099		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,296,665	0	1,296,665	8,538	151.87	30.00
31.00	INTENSIVE CARE UNIT	732,622		732,622	1,888	388.04	31.00
200.00	Total (lines 30-199)	2,029,287		2,029,287	10,426		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	655	99,475	30.00
31.00	INTENSIVE CARE UNIT	147	57,042	31.00
200.00	Total (lines 30-199)	802	156,517	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | 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	3,553,051	41,222,169	0.086193	506,084	43,621	50.00
51.00	05100	RECOVERY ROOM	676,066	5,944,494	0.113730	83,144	9,456	51.00
53.00	05300	ANESTHESIOLOGY	9,244	10,262,620	0.000901	5,416	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,078	25,019,457	0.002321	151,724	352	54.00
57.00	05700	CT SCAN	24,022	23,393,415	0.001027	219,400	225	57.00
58.00	05800	MRI	19,192	17,757,134	0.001081	92,287	100	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,405	16,913,862	0.001857	422,096	784	59.00
60.00	06000	LABORATORY	318,928	16,251,890	0.019624	548,612	10,766	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	123,121	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	157,904	3,585,497	0.044040	139,712	6,153	65.00
66.00	06600	PHYSICAL THERAPY	4,010	871,671	0.004600	56,894	262	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	440	37,021	0.011885	770	9	68.00
69.00	06900	ELECTROCARDIOLOGY	8,525	7,513,177	0.001135	85,126	97	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179,447	5,405,594	0.033197	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,155	8,789,102	0.003545	108,336	384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,243	12,424,201	0.003883	719,070	2,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360,089	15,724,414	0.022900	753,444	17,254	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	3,334	200,357	0.016640	113	2	76.01
76.02	03952	WOUND CARE	2,732	315,344	0.008664	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC	17,338	6,170,539	0.002810	0	0	90.02
91.00	09100	EMERGENCY	44,070	13,007,205	0.003388	131,390	445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	372,082	4,375,133	0.085045	0	0	92.00
200.00		Total (lines 50-199)	6,042,476	235,184,296		4,023,618	92,707	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
200.00		Total (lines 30-199)	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	8,538	0.00	655	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,888	0.00	147	0		31.00
200.00		Total (lines 30-199)	10,426		802	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,222,169	0.000000	0.000000	506,084	50.00
51.00	05100	RECOVERY ROOM	0	5,944,494	0.000000	0.000000	83,144	51.00
53.00	05300	ANESTHESIOLOGY	0	10,262,620	0.000000	0.000000	5,416	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,019,457	0.000000	0.000000	151,724	54.00
57.00	05700	CT SCAN	0	23,393,415	0.000000	0.000000	219,400	57.00
58.00	05800	MRI	0	17,757,134	0.000000	0.000000	92,287	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,913,862	0.000000	0.000000	422,096	59.00
60.00	06000	LABORATORY	0	16,251,890	0.000000	0.000000	548,612	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	3,585,497	0.000000	0.000000	139,712	65.00
66.00	06600	PHYSICAL THERAPY	0	871,671	0.000000	0.000000	56,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,021	0.000000	0.000000	770	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,513,177	0.000000	0.000000	85,126	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,405,594	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,789,102	0.000000	0.000000	108,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,424,201	0.000000	0.000000	719,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,724,414	0.000000	0.000000	753,444	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	200,357	0.000000	0.000000	113	76.01
76.02	03952	WOUND CARE	0	315,344	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	6,170,539	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	13,007,205	0.000000	0.000000	131,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,375,133	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	235,184,296			4,023,618	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0		64.01
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 PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0		76.01
76.02	03952	WOUND CARE	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | 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)	8,538	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,538	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)	6,088	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)	3,208	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)	8,850,290	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)	8,850,290	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)	8,850,290	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)	1,036.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,325,349	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)	3,325,349	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,368,073	1,888	1,783.94	309	551,237	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,606,344	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,482,930	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)	607,103	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	343,735	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	950,838	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,532,092	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,450	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,036.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,539,621	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | 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	1,296,665	8,850,290	0.146511	2,539,621	372,082	90.00
91.00	Nursing School cost	0	8,850,290	0.000000	2,539,621	0	91.00
92.00	Allied health cost	0	8,850,290	0.000000	2,539,621	0	92.00
93.00	All other Medical Education	0	8,850,290	0.000000	2,539,621	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | 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)	8,538	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,538	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)	6,088	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)	655	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)	8,850,290	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)	8,850,290	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)	8,850,290	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)	1,036.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	678,960	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)	678,960	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,368,073	1,888	1,783.94	147	262,239	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,193,852	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,135,051	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	156,517	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	92,707	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	249,224	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,885,827	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,450	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,036.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,539,621	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | 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	1,296,665	8,850,290	0.146511	2,539,621	372,082	90.00
91.00	Nursing School cost	0	8,850,290	0.000000	2,539,621	0	91.00
92.00	Allied health cost	0	8,850,290	0.000000	2,539,621	0	92.00
93.00	All other Medical Education	0	8,850,290	0.000000	2,539,621	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | 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		4,979,688		30.00
31.00	03100	INTENSIVE CARE UNIT		1,118,965		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.310415	489,871	152,063	50.00
51.00	05100	RECOVERY ROOM	0.550429	249,769	137,480	51.00
53.00	05300	ANESTHESIOLOGY	0.076070	488,961	37,195	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159862	903,036	144,361	54.00
57.00	05700	CT SCAN	0.069140	1,412,631	97,669	57.00
58.00	05800	MRI	0.081244	374,650	30,438	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103569	4,177,707	432,681	59.00
60.00	06000	LABORATORY	0.250504	2,905,163	727,755	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.347802	1,631,829	567,553	65.00
66.00	06600	PHYSICAL THERAPY	0.320517	405,325	129,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.835850	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062905	792,577	49,857	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.412252	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427901	980,596	419,598	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501829	2,043,774	1,025,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332088	3,219,957	1,069,309	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1.197303	0	0	76.01
76.02	03952	WOUND CARE	0.654507	1,706	1,117	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	CLINIC	0.209446	0	0	90.02
91.00	09100	EMERGENCY	0.244562	1,275,229	311,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580467	468,341	271,856	92.00
200.00		Total (sum of lines 50-94 and 96-98)		21,821,122	5,606,344	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)		21,821,122		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 1:49 pm

Title XIX | Hospital | 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		881,896		30.00
31.00	03100	INTENSIVE CARE UNIT		280,067		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.310415	506,084	157,096	50.00
51.00	05100	RECOVERY ROOM	0.550429	83,144	45,765	51.00
53.00	05300	ANESTHESIOLOGY	0.076070	5,416	412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159862	151,724	24,255	54.00
57.00	05700	CT SCAN	0.069140	219,400	15,169	57.00
58.00	05800	MRI	0.081244	92,287	7,498	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103569	422,096	43,716	59.00
60.00	06000	LABORATORY	0.250504	548,612	137,430	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.347802	139,712	48,592	65.00
66.00	06600	PHYSICAL THERAPY	0.320517	56,894	18,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.835850	770	644	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062905	85,126	5,355	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.412252	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427901	108,336	46,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501829	719,070	360,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332088	753,444	250,210	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1.197303	113	135	76.01
76.02	03952	WOUND CARE	0.654507	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	CLINIC	0.209446	0	0	90.02
91.00	09100	EMERGENCY	0.244562	131,390	32,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580467	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,023,618	1,193,852	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)		4,023,618		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 1:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,591,617	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,878,101	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)	483,680	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	56.31	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.30	30.00
31.00	Percentage of Medicaid patient days (see instructions)	10.06	31.00
32.00	Sum of lines 30 and 31	12.36	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 1:49 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000003292	0.000002600	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		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 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	6,953,398		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)	6,953,398	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	578,169	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	3,107	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 intructions)	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)	7,534,674	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,534,674	61.00
62.00	Deductibles billed to program beneficiaries	739,228	62.00
63.00	Coinsurance billed to program beneficiaries	17,710	63.00
64.00	Allowable bad debts (see instructions)	54,060	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	35,139	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,493	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,812,875	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)	-20,120	70.93
70.94	HRR adjustment amount (see instructions)	-14,623	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 1:49 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		53,282	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,724,850	71.00
71.01	Sequestration adjustment (see instructions)		134,497	71.01
72.00	Interim payments		6,555,852	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)		34,501	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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	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	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	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 1:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,108	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,266,380	2.00
3.00	PPS payments	8,130,231	3.00
4.00	Outlier payment (see instructions)	14,598	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)	6,108	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	18,402	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)	18,402	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 chargebasis 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)	18,402	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	12,294	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)	6,108	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)	8,144,829	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)	1,640,018	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)	6,510,919	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)	6,510,919	30.00
31.00	Primary payer payments	7,305	31.00
32.00	Subtotal (line 30 minus line 31)	6,503,614	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)	180,048	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	117,031	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,636	36.00
37.00	Subtotal (see instructions)	6,620,645	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)	6,620,645	40.00
40.01	Sequestration adjustment (see instructions)	132,413	40.01
41.00	Interim payments	6,367,559	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	120,673	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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 1:49 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,555,852		6,367,559	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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)		6,555,852		6,367,559	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		34,501		120,673	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,590,353		6,488,232	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: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 1:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,836	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,517	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	776	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	7,976	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	250,432,018	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,324,689	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/30/2017 1:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	93,621,375	0	0	0	1.00
2.00	Temporary investments	6,323,996	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,698,195	0	0	0	4.00
5.00	Other receivable	258,773	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,723,418	0	0	0	6.00
7.00	Inventory	1,674,847	0	0	0	7.00
8.00	Prepaid expenses	337,009	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	112,190,777	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,869,989	0	0	0	12.00
13.00	Land improvements	2,638,876	0	0	0	13.00
14.00	Accumulated depreciation	-573,576	0	0	0	14.00
15.00	Buildings	49,751,780	0	0	0	15.00
16.00	Accumulated depreciation	-5,399,204	0	0	0	16.00
17.00	Leasehold improvements	5,034,517	0	0	0	17.00
18.00	Accumulated depreciation	-2,489,995	0	0	0	18.00
19.00	Fixed equipment	74,828,191	0	0	0	19.00
20.00	Accumulated depreciation	-20,519,222	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	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	111,141,356	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	3,803,554	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,803,554	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	227,135,687	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,865,580	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,872,489	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	314,012	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	931,636	0	0	0	43.00
44.00	Other current liabilities	172,486,277	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	182,469,994	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,182,339	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	359,845	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,542,184	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	184,012,178	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,123,509				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)	43,123,509	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	227,135,687	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/30/2017 1:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		46,177,237		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		192,376				2.00
3.00	Total (sum of line 1 and line 2)		46,369,613		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		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)		46,369,613		0		11.00
12.00	EQUITY TRANSFERS	3,246,104		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,246,104		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		43,123,509		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	EQUITY TRANSFERS		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: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2017 1:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,465,664		10,465,664	1.00
2.00	SUBPROVIDER - IPF				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)	10,465,664		10,465,664	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,782,058		4,782,058	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,782,058		4,782,058	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,247,722		15,247,722	17.00
18.00	Ancillary services	49,832,771	179,140,001	228,972,772	18.00
19.00	Outpatient services	0	6,170,539	6,170,539	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	PHYSICIAN PRIVATE OFFICES	0	751,259	751,259	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	65,080,493	186,061,799	251,142,292	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		69,970,009		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		69,970,009		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/30/2017 1:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	251,142,292	1.00
2.00	Less contractual allowances and discounts on patients' accounts	183,010,410	2.00
3.00	Net patient revenues (line 1 minus line 2)	68,131,882	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	69,970,009	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,838,127	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	21,113	6.00
7.00	Income from investments	26,563	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	358,096	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	79,334	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	1,325	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	423,017	22.00
23.00	Governmental appropriations	3,219	23.00
24.00	OTHER OPERATING REVENUE	1,117,836	24.00
25.00	Total other income (sum of lines 6-24)	2,030,503	25.00
26.00	Total (line 5 plus line 25)	192,376	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)	192,376	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0165	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/30/2017 1:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	520,342	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	57,827	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)	21.79	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	578,169	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