This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 2:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2017 Time: 2:51 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 ALTON MEMORIAL HOSPITAL (14-0002) 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

		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	39,102	-27,790	1,298	0	1.00
2.00	Subprovider - IPF	0	23,169	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
7.00	SKILLED NURSING FACILITY	0	700	0		0	7.00
200.00	Total	0	62,971	-27,790	1,298	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2017 2:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ONE MEMORIAL DRIVE	PO Box:			1.00
2.00	City: ALTON	State: IL	Zip Code: 62002-	County: MADISON	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	ALTON MEMORIAL HOSPITAL	140002	41180	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	ALTON MEMORIAL HOSPITAL PSYCH	14S002	41180	4	01/01/2008	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	ALTON MEMORIAL HOSPITAL SNF	145566	41180		10/15/1986	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,757	480	54	0	2,695	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: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 2:49 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)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 2:49 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: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 2:49 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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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.		Y	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: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2017 2:49 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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	2,430,000	1,700,004	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: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 2:49 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	269026	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: BJC HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 05301	141.00
142.00	Street: 4901 FOREST PARK AVENUE	PO Box:		142.00
143.00	City: ST. LOUIS	State: MO	Zip Code: 63108	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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 2:49 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: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2017 2:49 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)	Y			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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/05/2017	Y	04/05/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Y		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 2:49 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	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.				Y	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.	PAUL		BRADSHAW		41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-7419		PJB1541@BJC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 2:49 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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part IX Date/Time Prepared: 5/24/2017 2:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2017 2:49 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	120	43,920	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)		120	43,920	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	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)		132	48,312	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,320		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	24	8,784		0	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)		176				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2017 2:49 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)	9,532	2,177	21,216			1.00
2.00	HMO and other (see instructions)	3,418	2,695				2.00
3.00	HMO IPF Subprovider	140	4				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)	9,532	2,177	21,216			7.00
8.00	INTENSIVE CARE UNIT	1,228	114	2,682			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)	10,760	2,291	23,898	0.00	693.48	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,500	21	2,781	0.00	16.60	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,773	42	4,671	0.00	23.21	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	733.29	27.00
28.00	Observation Bed Days		0	1,707			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2017 2:49 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	2,773	731	6,838	1.00
2.00	HMO and other (see instructions)			931	1,033		2.00
3.00	HMO IPF Subprovider				1		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	2,773	731	6,838	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	188	2	234	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2017 2:49 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	43,617,503	0	43,617,503	1,552,065.00	28.10	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		198,274	0	198,274	1,233.00	160.81	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	1,419,876	0	1,419,876	47,805.00	29.70	9.00
10.00	Excluded area salaries (see instructions)		4,184,868	33,268	4,218,136	182,981.00	23.05	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,010,174	0	1,010,174	14,540.00	69.48	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		367,535	0	367,535	2,429.00	151.31	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		8,247,563	0	8,247,563	188,739.00	43.70	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)		10,061,210	0	10,061,210			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,508,856	0	1,508,856			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		45,276	0	45,276			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		1,176,426	0	1,176,426			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	1,253,010	0	1,253,010	71,546.00	17.51	26.00
27.00	Administrative & General	5.00	3,062,805	0	3,062,805	71,372.00	42.91	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2017 2:49 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.)		1,241,357	0	1,241,357	12,507.00	99.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	821,832	0	821,832	32,133.00	25.58	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	995,113	0	995,113	80,160.00	12.41	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,548,164	0	1,548,164	78,049.00	19.84	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	1,018,120	0	1,018,120	34,238.00	29.74	38.00
39.00	Central Services and Supply	14.00	268,476	0	268,476	14,659.00	18.31	39.00
40.00	Pharmacy	15.00	1,731,322	0	1,731,322	41,617.00	41.60	40.00
41.00	Medical Records & Medical Records Library	16.00	301,762	0	301,762	16,267.00	18.55	41.00
42.00	Social Service	17.00	1,057,259	0	1,057,259	31,203.00	33.88	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2017 2:49 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)		46,407,024	0	46,407,024	1,642,621.00	28.25	1.00
2.00	Excluded area salaries (see instructions)		5,604,744	33,268	5,638,012	230,786.00	24.43	2.00
3.00	Subtotal salaries (line 1 minus line 2)		40,802,280	-33,268	40,769,012	1,411,835.00	28.88	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,625,272	0	9,625,272	205,708.00	46.79	4.00
5.00	Subtotal wage-related costs (see inst.)		11,282,912	0	11,282,912	0.00	27.68	5.00
6.00	Total (sum of lines 3 thru 5)		61,710,464	-33,268	61,677,196	1,617,543.00	38.13	6.00
7.00	Total overhead cost (see instructions)		13,299,220	0	13,299,220	483,751.00	27.49	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2017 2:49 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,841,861	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	994,127	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)	0	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)	4,353,547	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	188,756	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,802	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)	462,478	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	458,665	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	3,125,720	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-3,225	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	164,611	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,615,342	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/24/2017 2:49 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	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/24/2017 2:49 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	12	0	12	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	14	0	14	13.00
14.00		RUA	21	0	21	14.00
15.00		RVC	20	0	20	15.00
16.00		RVB	152	0	152	16.00
17.00		RVA	375	0	375	17.00
18.00		RHC	118	0	118	18.00
19.00		RHB	234	0	234	19.00
20.00		RHA	879	0	879	20.00
21.00		RMC	103	0	103	21.00
22.00		RMB	149	0	149	22.00
23.00		RMA	244	0	244	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	9	0	9	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	11	0	11	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	4	0	4	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	18	0	18	43.00
44.00		LB1	30	0	30	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	7	0	7	47.00
48.00		CD1	14	0	14	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	23	0	23	50.00
51.00		CB2	1	0	1	51.00
52.00		CB1	98	0	98	52.00
53.00		CA2	4	0	4	53.00
54.00		CA1	170	0	170	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	3	0	3	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/24/2017 2:49 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	5	0	5	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	6	0	6	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	6	0	6	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	9	0	9	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	30	0	30	78.00
199.00		AAA	4	0	4	199.00
200.00	TOTAL		2,773	0	2,773	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	41180	41180	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,419,876	39.94	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,554,631			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/24/2017 2:49 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)	0.237053	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,926,003	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	6,765,636	5.00
6.00	Medicaid charges	80,848,205	6.00
7.00	Medicaid cost (line 1 times line 6)	19,165,310	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)	3,473,671	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	18,796	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,473,671	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	7,204,364	2,712,321	9,916,685	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,707,816	642,964	2,350,780	21.00
22.00	Partial payment by patients approved for charity care	91,158	134,479	225,637	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,616,658	508,485	2,125,143	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)	7,384,429	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	861,829	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,522,600	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,546,202	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,671,345	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,145,016	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/24/2017 2:49 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	NEW CAP REL COSTS-BLDG & FIXT		0	0	4,629,133	4,629,133	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	6,733,180	6,733,180	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	241,974	680,087	922,061	-1,721	920,340	4.00
4.03	00401	ADMITTING	1,011,036	330,617	1,341,653	-7,064	1,334,589	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	3,062,805	35,092,718	38,155,523	-9,296,221	28,859,302	5.00
7.00	00700	OPERATION OF PLANT	821,832	2,430,094	3,251,926	-53,065	3,198,861	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	375,821	375,821	-262	375,559	8.00
9.00	00900	HOUSEKEEPING	995,113	528,090	1,523,203	-267	1,522,936	9.00
10.00	01000	DIETARY	0	2,699,614	2,699,614	-14,559	2,685,055	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,018,120	450,388	1,468,508	-52,795	1,415,713	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,476	249,326	517,802	-225,072	292,730	14.00
15.00	01500	PHARMACY	1,731,322	9,625,139	11,356,461	-189,737	11,166,724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301,762	190,105	491,867	-1,453	490,414	16.00
17.00	01700	SOCIAL SERVICE	1,057,259	289,021	1,346,280	-2,461	1,343,819	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,844,473	5,933,562	14,778,035	-437,717	14,340,318	30.00
31.00	03100	INTENSIVE CARE UNIT	1,962,157	1,114,788	3,076,945	-175,491	2,901,454	31.00
40.00	04000	SUBPROVIDER - IPF	1,227,440	403,971	1,631,411	-6,459	1,624,952	40.00
44.00	04400	SKILLED NURSING FACILITY	1,419,876	530,841	1,950,717	-40,422	1,910,295	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,700,576	11,667,894	14,368,470	-7,505,708	6,862,762	50.00
51.00	05100	RECOVERY ROOM	478,682	245,503	724,185	-9,104	715,081	51.00
53.00	05300	ANESTHESIOLOGY	32,862	429,951	462,813	-162,140	300,673	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,261,305	1,503,484	3,764,789	-482,224	3,282,565	54.00
56.00	05600	RADIOISOTOPE	171,024	240,747	411,771	1,809	413,580	56.00
57.00	05700	CT SCAN	264,717	396,803	661,520	-144,424	517,096	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	463,373	966,468	1,429,841	-109,374	1,320,467	58.00
59.00	05900	CARDIAC CATHETERIZATION	606,997	2,217,518	2,824,515	-1,867,447	957,068	59.00
60.00	06000	LABORATORY	1,330,616	2,185,484	3,516,100	-230,472	3,285,628	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	200,692	683,924	884,616	140,594	1,025,210	63.00
65.00	06500	RESPIRATORY THERAPY	832,725	424,210	1,256,935	-49,947	1,206,988	65.00
66.00	06600	PHYSICAL THERAPY	1,147,549	412,512	1,560,061	-51,643	1,508,418	66.00
67.00	06700	OCCUPATIONAL THERAPY	268,395	59,440	327,835	10,914	338,749	67.00
68.00	06800	SPEECH PATHOLOGY	147,160	39,961	187,121	8,077	195,198	68.00
69.00	06900	ELECTROCARDIOLOGY	806,778	442,656	1,249,434	3,099	1,252,533	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,099,808	2,099,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,133,041	8,133,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	348,163	348,163	-15,749	332,414	74.00
76.00	03020	ONCOLOGY	757,695	1,470,112	2,227,807	-47,909	2,179,898	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	815,474	719,528	1,535,002	-303,078	1,231,924	76.01
76.02	03550	OP PSYCH	392,834	127,342	520,176	-22,744	497,432	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	324,394	324,394	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,016,976	1,498,219	4,515,195	-277,006	4,238,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,019,895	1,442,678	3,462,573	-296,332	3,166,241	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,679,970	88,446,779	131,126,749	3,982	131,130,731	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,676	46,619	77,295	-1,650	75,645	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	10,184	4,960	15,144	-304	14,840	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	207,458	759,244	966,702	-1,329	965,373	193.01
193.02	19302	MEDICAL OFFICE BUILDING	262,308	494,302	756,610	0	756,610	193.02
193.03	19303	HOME CARE PHARMACY	350,915	1,437,459	1,788,374	-699	1,787,675	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	75,992	415,675	491,667	0	491,667	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	45,857	45,857	0	45,857	193.09
200.00		TOTAL (SUM OF LINES 118-199)	43,617,503	91,650,895	135,268,398	0	135,268,398	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	4,629,133		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-847,451	5,885,729		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	763,889	1,684,229		4.00
4.03	00401	ADMITTING	0	1,334,589		4.03
5.00	00500	ADMINISTRATIVE & GENERAL	-6,688,511	22,170,791		5.00
7.00	00700	OPERATION OF PLANT	-9,330	3,189,531		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	375,559		8.00
9.00	00900	HOUSEKEEPING	0	1,522,936		9.00
10.00	01000	DIETARY	441,967	3,127,022		10.00
11.00	01100	CAFETERIA	-567,630	-567,630		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,415,713		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	292,730		14.00
15.00	01500	PHARMACY	-660	11,166,064		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,785	482,629		16.00
17.00	01700	SOCIAL SERVICE	-85,000	1,258,819		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,082,466	12,257,852		30.00
31.00	03100	INTENSIVE CARE UNIT	-241,992	2,659,462		31.00
40.00	04000	SUBPROVIDER - IPF	-54,000	1,570,952		40.00
44.00	04400	SKILLED NURSING FACILITY	0	1,910,295		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-547,975	6,314,787		50.00
51.00	05100	RECOVERY ROOM	0	715,081		51.00
53.00	05300	ANESTHESIOLOGY	0	300,673		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-204,583	3,077,982		54.00
56.00	05600	RADIOISOTOPE	0	413,580		56.00
57.00	05700	CT SCAN	0	517,096		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-632,845	687,622		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	957,068		59.00
60.00	06000	LABORATORY	38,552	3,324,180		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,025,210		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,206,988		65.00
66.00	06600	PHYSICAL THERAPY	0	1,508,418		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	338,749		67.00
68.00	06800	SPEECH PATHOLOGY	0	195,198		68.00
69.00	06900	ELECTROCARDIOLOGY	-8,953	1,243,580		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,099,808		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,133,041		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	332,414		74.00
76.00	03020	ONCOLOGY	-1,094,567	1,085,331		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	1,231,924		76.01
76.02	03550	OP PSYCH	0	497,432		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	324,394		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	4,238,189		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,166,241		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-11,829,340	119,301,391		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	75,645		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	TWIN RIVERS MRI	0	0		192.01
193.00	19300	NONPAID WORKERS	0	14,840		193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	965,373		193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	756,610		193.02
193.03	19303	HOME CARE PHARMACY	0	1,787,675		193.03
193.04	19304	MANAGEMENT SERVICES	0	0		193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0		193.05
193.06	19306	VACANT SPACE	0	0		193.06
193.07	19307	POB 2	0	491,667		193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0		193.08
193.09	19309	COFFEE BAR	0	45,857		193.09
200.00		TOTAL (SUM OF LINES 118-199)	-11,829,340	123,439,058		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet Non-CMS W | Date/Time Prepared: 5/24/2017 2:49 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
4.03	ADMITTING	00401		4.03
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	ONCOLOGY	03020	ACUPUNCTURE	76.00
76.01	GASTRO INTESTINAL SERVICES	03340	GASTRO INTESTINAL SERVICES	76.01
76.02	OP PSYCH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02
76.98	HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
	OUTPATIENT SERVICE COST CENTERS			
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	TWIN RIVERS MRI	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.01	PHYSICIAN/PUBLIC RELATIONS	19301		193.01
193.02	MEDICAL OFFICE BUILDING	19302		193.02
193.03	HOME CARE PHARMACY	19303		193.03
193.04	MANAGEMENT SERVICES	19304		193.04
193.05	EUNICE SMITH NURSING HOME	19305		193.05
193.06	VACANT SPACE	19306		193.06
193.07	POB 2	19307		193.07
193.08	NON REIMBURSABLE MEALS	19308		193.08
193.09	COFFEE BAR	19309		193.09
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/24/2017 2:49 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,518,082		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,679,721		2.00
	0		0	11,197,803		
	B - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,232,849		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	0		0	10,232,849		
	C - TO RECLASS LAB ADMIN					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	73,906	72,031		1.00
	0		73,906	72,031		
	D - TO RECLASS DIRECTOR'S EXPENSE					
1.00	RECOVERY ROOM	51.00	20,846	1,595		1.00
2.00	ANESTHESIOLOGY	53.00	38,426	2,940		2.00
3.00	RADIOISOTOPE	56.00	3,588	274		3.00
4.00	OCCUPATIONAL THERAPY	67.00	14,787	1,131		4.00
5.00	SPEECH PATHOLOGY	68.00	7,503	574		5.00
6.00	ELECTROCARDIOLOGY	69.00	76,605	5,861		6.00
7.00	CT SCAN	57.00	37,630	2,879		7.00
8.00	GASTRO INTESTINAL SERVICES	76.01	37,422	2,864		8.00
9.00	AMBULANCE SERVICES	95.00	33,268	2,545		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	12,911	988		10.00
	0		282,986	21,651		
	E - TO RECLASS HYPERBARIC OXYGEN EXPENSE					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	324,394		1.00
	0		0	324,394		
	F - TO RECLASS DEPRECIATION DEPT EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,066,092		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

RECLASSIFICATIONS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/24/2017 2:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
	0		0	2,066,092		
	G - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	164,510		1.00
	0		0	164,510		
	H - TO RECLASS MEDICAL IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,133,041		1.00
	0		0	8,133,041		
500.00	Grand Total: Increases		356,892	32,212,371		500.00

RECLASSIFICATIONS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/24/2017 2:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,197,803	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	11,197,803			
	B - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	181,127	0		1.00
2.00	PHARMACY	15.00	0	185,230	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	315,639	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	109,378	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	6,143	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	30,542	0		6.00
7.00	OPERATING ROOM	50.00	0	6,856,960	0		7.00
8.00	RECOVERY ROOM	51.00	0	31,283	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	149,225	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,816	0		10.00
11.00	RADIOISOTOPE	56.00	0	1,032	0		11.00
12.00	CT SCAN	57.00	0	15,481	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	1,794,836	0		13.00
14.00	LABORATORY	60.00	0	921	0		14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,288	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,840	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	12,194	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	2,379	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	356	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	10,975	0		20.00
21.00	RENAL DIALYSIS	74.00	0	15,749	0		21.00
22.00	ONCOLOGY	76.00	0	37,688	0		22.00
23.00	GASTRO INTESTINAL SERVICES	76.01	0	215,021	0		23.00
24.00	OP PSYCH	76.02	0	263	0		24.00
25.00	EMERGENCY	91.00	0	185,645	0		25.00
26.00	AMBULANCE SERVICES	95.00	0	39,838	0		26.00
	0		0	10,232,849			
	C - TO RECLASS LAB ADMIN						
1.00	LABORATORY	60.00	73,906	72,031	0		1.00
	0		73,906	72,031			
	D - TO RECLASS DIRECTOR'S EXPENSE						
1.00	OPERATING ROOM	50.00	96,694	7,399	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	54,129	4,141	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	45,025	3,444	0		3.00
4.00	RESPIRATORY THERAPY	65.00	31,580	2,417	0		4.00
5.00	PHYSICAL THERAPY	66.00	22,290	1,705	0		5.00
6.00	EMERGENCY	91.00	33,268	2,545	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	0		282,986	21,651			
	E - TO RECLASS HYPERBARIC OXYGEN EXPENSE						
1.00	OPERATING ROOM	50.00	0	324,394	0		1.00
	0		0	324,394			
	F - TO RECLASS DEPRECIATION DEPT EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,721	0		1.00
2.00	ADMITTING	4.03	0	7,064	0		2.00
3.00	OPERATION OF PLANT	7.00	0	53,065	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	262	0		4.00
5.00	HOUSEKEEPING	9.00	0	267	0		5.00
6.00	DIETARY	10.00	0	14,559	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	52,795	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	43,945	0		8.00
9.00	PHARMACY	15.00	0	4,507	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,453	0		10.00
11.00	SOCIAL SERVICE	17.00	0	2,461	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	122,078	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	66,113	0		13.00
14.00	SUBPROVIDER - IPF	40.00	0	316	0		14.00
15.00	SKILLED NURSING FACILITY	44.00	0	9,880	0		15.00
16.00	OPERATING ROOM	50.00	0	220,261	0		16.00
17.00	RECOVERY ROOM	51.00	0	262	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	54,281	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	392,138	0		19.00
20.00	RADIOISOTOPE	56.00	0	1,021	0		20.00

RECLASSIFICATIONS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/24/2017 2:49 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	122,917	0		21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	24,142	0		22.00
23.00	LABORATORY	60.00	0	83,614	0		23.00
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	4,055	0		24.00
25.00	RESPIRATORY THERAPY	65.00	0	14,110	0		25.00
26.00	PHYSICAL THERAPY	66.00	0	15,454	0		26.00
27.00	OCCUPATIONAL THERAPY	67.00	0	2,625	0		27.00
28.00	ELECTROCARDIOLOGY	69.00	0	68,392	0		28.00
29.00	ONCOLOGY	76.00	0	10,221	0		29.00
30.00	GASTRO INTESTINAL SERVICES	76.01	0	128,343	0		30.00
31.00	OP PSYCH	76.02	0	22,481	0		31.00
32.00	EMERGENCY	91.00	0	55,548	0		32.00
33.00	AMBULANCE SERVICES	95.00	0	292,307	0		33.00
34.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,650	0		34.00
35.00	NONPAID WORKERS	193.00	0	304	0		35.00
36.00	PHYSICIAN/PUBLIC RELATIONS	193.01	0	1,329	0		36.00
37.00	HOME CARE PHARMACY	193.03	0	699	0		37.00
38.00	CT SCAN	57.00	0	169,452	0		38.00
	0		0	2,066,092			
	G - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	164,510	12		1.00
	0		0	164,510			
	H - TO RECLASS MEDICAL IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,133,041	0		1.00
	0		0	8,133,041			
500.00	Grand Total: Decreases		356,892	32,212,371			500.00

RECLASSIFICATIONS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/24/2017 2:49 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS DEPRECIATION								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,518,082	ADMINISTRATIVE & GENERAL	5.00	0	11,197,803	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,679,721		0.00	0	0	2.00
	0		0	11,197,803	0		0	11,197,803	
	B - RECLASS MEDICAL SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,232,849	CENTRAL SERVICES & SUPPLY	14.00	0	181,127	1.00
2.00		0.00	0	0	PHARMACY	15.00	0	185,230	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	315,639	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	109,378	4.00
5.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	6,143	5.00
6.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	30,542	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	6,856,960	7.00
8.00		0.00	0	0	RECOVERY ROOM	51.00	0	31,283	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	149,225	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	31,816	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	1,032	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	15,481	12.00
13.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,794,836	13.00
14.00		0.00	0	0	LABORATORY	60.00	0	921	14.00
15.00		0.00	0	0	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,288	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,840	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	12,194	17.00
18.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	2,379	18.00
19.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	356	19.00
20.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	10,975	20.00
21.00		0.00	0	0	RENAL DIALYSIS	74.00	0	15,749	21.00
22.00		0.00	0	0	ONCOLOGY	76.00	0	37,688	22.00
23.00		0.00	0	0	GASTRO INTESTINAL SERVICES	76.01	0	215,021	23.00
24.00		0.00	0	0	OP PSYCH	76.02	0	263	24.00
25.00		0.00	0	0	EMERGENCY	91.00	0	185,645	25.00
26.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	39,838	26.00
	0		0	10,232,849	0		0	10,232,849	
	C - TO RECLASS LAB ADMIN								
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	73,906	72,031	LABORATORY	60.00	73,906	72,031	1.00
	0		73,906	72,031	0		73,906	72,031	
	D - TO RECLASS DIRECTOR'S EXPENSE								
1.00	RECOVERY ROOM	51.00	20,846	1,595	OPERATING ROOM	50.00	96,694	7,399	1.00
2.00	ANESTHESIOLOGY	53.00	38,426	2,940	RADIOLOGY-DIAGNOSTIC	54.00	54,129	4,141	2.00
3.00	RADIOISOTOPE	56.00	3,588	274	CARDIAC CATHETERIZATION	59.00	45,025	3,444	3.00
4.00	OCCUPATIONAL THERAPY	67.00	14,787	1,131	RESPIRATORY THERAPY	65.00	31,580	2,417	4.00
5.00	SPEECH PATHOLOGY	68.00	7,503	574	PHYSICAL THERAPY	66.00	22,290	1,705	5.00
6.00	ELECTROCARDIOLOGY	69.00	76,605	5,861	EMERGENCY	91.00	33,268	2,545	6.00
7.00	CT SCAN	57.00	37,630	2,879		0.00	0	0	7.00
8.00	GASTRO INTESTINAL SERVICES	76.01	37,422	2,864		0.00	0	0	8.00
9.00	AMBULANCE SERVICES	95.00	33,268	2,545		0.00	0	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	12,911	988		0.00	0	0	10.00
	0		282,986	21,651	0		282,986	21,651	
	E - TO RECLASS HYPERBARIC OXYGEN EXPENSE								
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	324,394	OPERATING ROOM	50.00	0	324,394	1.00
	0		0	324,394	0		0	324,394	
	F - TO RECLASS DEPRECIATION DEPT EXPENSE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,066,092	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,721	1.00
2.00		0.00	0	0	ADMITTING	4.03	0	7,064	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	53,065	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	262	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	267	5.00
6.00		0.00	0	0	DIETARY	10.00	0	14,559	6.00
7.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	52,795	7.00

RECLASSIFICATIONS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/24/2017 2:49 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
8.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	43,945	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	4,507	9.00
10.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	1,453	10.00
11.00		0.00	0	0	SOCIAL SERVICE	17.00	0	2,461	11.00
12.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	122,078	12.00
13.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	66,113	13.00
14.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	316	14.00
15.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	9,880	15.00
16.00		0.00	0	0	OPERATING ROOM	50.00	0	220,261	16.00
17.00		0.00	0	0	RECOVERY ROOM	51.00	0	262	17.00
18.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	54,281	18.00
19.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	392,138	19.00
20.00		0.00	0	0	RADIOISOTOPE	56.00	0	1,021	20.00
21.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	122,917	21.00
22.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	24,142	22.00
23.00		0.00	0	0	LABORATORY	60.00	0	83,614	23.00
24.00		0.00	0	0	BLOOD STORING, PROCESSING & TRANS.	63.00	0	4,055	24.00
25.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	14,110	25.00
26.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	15,454	26.00
27.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	2,625	27.00
28.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	68,392	28.00
29.00		0.00	0	0	ONCOLOGY	76.00	0	10,221	29.00
30.00		0.00	0	0	GASTRO INTESTINAL SERVICES	76.01	0	128,343	30.00
31.00		0.00	0	0	OP PSYCH	76.02	0	22,481	31.00
32.00		0.00	0	0	EMERGENCY	91.00	0	55,548	32.00
33.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	292,307	33.00
34.00		0.00	0	0	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,650	34.00
35.00		0.00	0	0	NONPAID WORKERS	193.00	0	304	35.00
36.00		0.00	0	0	PHYSICIAN/PUBLIC RELATIONS	193.01	0	1,329	36.00
37.00		0.00	0	0	HOME CARE PHARMACY	193.03	0	699	37.00
38.00		0.00	0	0	CT SCAN	57.00	0	169,452	38.00
	0		0	2,066,092	0		0	2,066,092	
	G - TO RECLASS PROPERTY INSURANCE								
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	164,510	ADMINISTRATIVE & GENERAL	5.00	0	164,510	1.00
	0		0	164,510	0		0	164,510	
	H - TO RECLASS MEDICAL IMPLANTS								
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,133,041	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,133,041	1.00
	0		0	8,133,041	0		0	8,133,041	
500.00	Grand Total: Increases		356,892	32,212,371	Grand Total: Decreases		356,892	32,212,371	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2017 2:49 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	177,168	0	0	0	0	1.00
2.00	Land Improvements	5,757,596	358,730	0	358,730	0	2.00
3.00	Buildings and Fixtures	67,087,048	67,659	0	67,659	72,423	3.00
4.00	Building Improvements	16,699,687	175,180	0	175,180	0	4.00
5.00	Fixed Equipment	36,538,254	385,593	0	385,593	0	5.00
6.00	Movable Equipment	61,402,318	4,754,850	0	4,754,850	10,320,188	6.00
7.00	HIT designated Assets	5,193,570	105,368	0	105,368	0	7.00
8.00	Subtotal (sum of lines 1-7)	192,855,641	5,847,380	0	5,847,380	10,392,611	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	192,855,641	5,847,380	0	5,847,380	10,392,611	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	177,168	0	1.00
2.00	Land Improvements	6,116,326	0	2.00
3.00	Buildings and Fixtures	67,082,284	0	3.00
4.00	Building Improvements	16,874,867	0	4.00
5.00	Fixed Equipment	36,923,847	0	5.00
6.00	Movable Equipment	55,836,980	0	6.00
7.00	HIT designated Assets	5,298,938	0	7.00
8.00	Subtotal (sum of lines 1-7)	188,310,410	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	188,310,410	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2017 2:49 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2017 2:49 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	NEW CAP REL COSTS-BLDG & FIXT	126,997,324	0	126,997,324	0.675039	111,051	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	61,135,918	0	61,135,918	0.324961	53,459	2.00
3.00	Total (sum of lines 1-2)	188,133,242	0	188,133,242	1.000000	164,510	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	111,051	4,518,082	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	53,459	5,832,270	0	2.00
3.00	Total (sum of lines 1-2)	0	0	164,510	10,350,352	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	NEW CAP REL COSTS-BLDG & FIXT	0	111,051	0	0	4,629,133	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	53,459	0	0	5,885,729	2.00
3.00	Total (sum of lines 1-2)	0	164,510	0	0	10,514,862	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/24/2017 2:49 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-548	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,103,048			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,096,003			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-567,630	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/24/2017 2:49 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	
33.00	ASSOCIATION DUES	A	-33,226	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE -MRI	A	-2,845	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.01
33.02	ELIMINATE FINANCING COSTS	A	-31,870	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NON OPERATING DONATIONS	B	956	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER NON OPERATING REVENUE	B	-404,567	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MALPRACTICE EXPENSE	A	-1,700,004	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ESH DIETARY COSTS	A	478,162	DIETARY	10.00	0	33.06
33.07	OTHER REVENUE - A&G	B	-710,140	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER REVENUE - PLANT OPERATIONS	B	-8,782	OPERATION OF PLANT	7.00	0	33.08
33.09	OTHER REVENUE - PHARMACY	B	-660	PHARMACY	15.00	0	33.09
33.10	OTHER REVENUE - MEDICAL RECORDS	B	-7,785	MEDICAL RECORDS & LIBRARY	16.00	0	33.10
33.11	OTHER REVENUE - SOCIAL SERVICE	B	-85,000	SOCIAL SERVICE	17.00	0	33.11
33.12	OTHER REVENUE - RADIOLOGY	B	-107	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	OTHER REVENUE - LAB	B	-720	LABORATORY	60.00	0	33.13
33.14	OTHER REVENUE - EKG	B	-8,953	ELECTROCARDIOLOGY	69.00	0	33.14
33.15	ASBESTOS ABATEMENT	A	-561	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PRIOR YR ADJUSTMENT TOWER GROVE RAMP	A	19,363	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	ENTERTAINMENT EXPENSE	A	-11,071	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.19	PENSION EXPENSE	A	777,920	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	ALCOHOLIC BEVERAGES	A	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	DISALLOWED INTEREST EXPENSE	A	-441,154	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	ENTERTAINMENT EXPENSE	A	-4,441	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	ACCELERATED DEPRECIATION	A	-847,451	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.23
33.24	VENDING MACHINE REVENUE	B	-36,195	DIETARY	10.00	0	33.24
33.25	NON ALLOWABLE EMPLOYEE ACTIVITIES	A	-2,960	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26			0		0.00	0	33.26
33.27			0		0.00	0	33.27
33.28			0		0.00	0	33.28
33.29			0		0.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32			0		0.00	0	33.32
33.33			0		0.00	0	33.33
33.34			0		0.00	0	33.34
33.35			0		0.00	0	33.35
34.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,829,340				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2017 2:49 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	5.00	ADMINISTRATIVE & GENERAL	BJC HEALTH SYSTEM	13,702,641	16,833,411	1.00
2.00	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIE	11,725	17,427	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TELEPHONE FACILITIES CORP	66,828	65,631	3.00
4.00	60.00	LABORATORY	BARNES JEWISH LAB	157,386	118,375	4.00
4.01	60.00	LABORATORY	CHILDREN'S HOSPITAL LAB	789	528	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
5.00	0		0	13,939,369	17,035,372	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	G	BJC HEALTHCARE	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:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/24/2017 2:49 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	-3,130,770	0		1.00
2.00	-5,702	0		2.00
3.00	1,197	0		3.00
4.00	39,011	0		4.00
4.01	261	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
5.00	-3,096,003			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: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2017 2:49 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	AGGREGATE-ADULTS & PEDIATRICS	1,860,455	1,860,455	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	222,011	222,011	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	241,992	241,992	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	54,000	54,000	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	542,273	542,273	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	204,476	204,476	0	0	0	6.00
7.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	630,000	630,000	0	0	0	7.00
8.00	76.00	AGGREGATE-ONCOLOGY	1,094,567	1,094,567	0	0	0	8.00
9.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	163,568	163,568	0	0	0	9.00
10.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	80,485	80,485	0	0	0	10.00
11.00	5.00	DR. A	8,250	0	8,250	211,500	17	11.00
12.00	5.00	DR. B	1,322	0	1,322	211,500	13	12.00
13.00	5.00	DR. C	2,700	2,700	0	0	0	13.00
200.00			5,106,099	5,096,527	9,572		30	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	0	0	7.00
8.00	76.00	AGGREGATE-ONCOLOGY	0	0	0	0	0	8.00
9.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	10.00
11.00	5.00	DR. A	1,729	86	0	0	0	11.00
12.00	5.00	DR. B	1,322	66	0	0	0	12.00
13.00	5.00	DR. C	0	0	0	0	0	13.00
200.00			3,051	152	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,860,455		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	222,011		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	241,992		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	54,000		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	542,273		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	204,476		6.00
7.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	630,000		7.00
8.00	76.00	AGGREGATE-ONCOLOGY	0	0	0	1,094,567		8.00
9.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	163,568		9.00
10.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	80,485		10.00
11.00	5.00	DR. A	0	1,729	6,521	6,521		11.00
12.00	5.00	DR. B	0	1,322	0	0		12.00
13.00	5.00	DR. C	0	0	0	2,700		13.00
200.00			0	3,051	6,521	5,103,048		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,629,133	4,629,133				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	5,885,729		5,885,729			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,684,229	25,214	1,711	1,711,154		4.00
4.03	00401	ADMITTING	1,334,589	55,645	7,024	39,885	1,437,143	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	22,170,791	260,810	4,020,034	120,828	0	5.00
7.00	00700	OPERATION OF PLANT	3,189,531	1,800,907	26,657	32,421	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	375,559	11,275	261	0	0	8.00
9.00	00900	HOUSEKEEPING	1,522,936	26,659	266	39,257	0	9.00
10.00	01000	DIETARY	3,127,022	110,644	10,467	0	0	10.00
11.00	01100	CAFETERIA	-567,630	47,845	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,415,713	5,074	38,722	40,165	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	292,730	45,672	43,699	10,591	0	14.00
15.00	01500	PHARMACY	11,166,064	28,391	4,482	68,301	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	482,629	54,435	1,445	11,905	0	16.00
17.00	01700	SOCIAL SERVICE	1,258,819	5,371	2,447	41,709	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,257,852	562,424	121,394	348,905	115,034	30.00
31.00	03100	INTENSIVE CARE UNIT	2,659,462	56,250	65,742	77,407	27,262	31.00
40.00	04000	SUBPROVIDER - IPF	1,570,952	75,314	314	48,423	15,468	40.00
44.00	04400	SKILLED NURSING FACILITY	1,910,295	39,625	9,825	56,014	10,532	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,314,787	212,217	197,140	102,723	88,743	50.00
51.00	05100	RECOVERY ROOM	715,081	34,654	261	19,706	15,726	51.00
53.00	05300	ANESTHESIOLOGY	300,673	2,501	53,977	2,812	28,988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,077,982	111,915	389,939	86,317	97,986	54.00
56.00	05600	RADIOISOTOPE	413,580	10,260	1,015	6,888	11,567	56.00
57.00	05700	CT SCAN	517,096	5,832	168,502	11,928	121,307	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	687,622	49,270	2,989	18,789	41,622	58.00
59.00	05900	CARDIAC CATHETERIZATION	957,068	18,049	24,007	22,170	30,711	59.00
60.00	06000	LABORATORY	3,324,180	147,399	83,145	49,577	142,396	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,025,210	3,731	4,032	10,833	17,206	63.00
65.00	06500	RESPIRATORY THERAPY	1,206,988	15,805	14,031	31,605	21,631	65.00
66.00	06600	PHYSICAL THERAPY	1,508,418	55,604	15,367	44,391	21,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	338,749	14,975	2,610	11,172	5,374	67.00
68.00	06800	SPEECH PATHOLOGY	195,198	5,125	0	6,101	2,727	68.00
69.00	06900	ELECTROCARDIOLOGY	1,243,580	51,781	68,009	38,724	67,066	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,099,808	0	0	0	29,216	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,133,041	0	0	0	84,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	168,445	73.00
74.00	07400	RENAL DIALYSIS	332,414	2,870	0	0	3,486	74.00
76.00	03020	ONCOLOGY	1,085,331	18,213	10,164	26,773	10,375	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,231,924	35,074	127,623	33,647	28,231	76.01
76.02	03550	OP PSYCH	497,432	39,789	22,355	15,497	7,621	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	324,394	0	0	0	9,340	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,238,189	170,409	51,445	117,707	157,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,166,241	10,004	290,668	80,997	55,295	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,301,391	4,227,032	5,881,769	1,674,168	1,437,143	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	75,645	10,619	1,641	1,210	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	14,840	16,358	302	402	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	965,373	10,670	1,322	8,184	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	756,610	0	0	10,348	0	193.02
193.03	19303	HOME CARE PHARMACY	1,787,675	4,930	695	13,844	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	357,659	0	0	0	193.06
193.07	19307	POB 2	491,667	0	0	2,998	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	45,857	1,865	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	123,439,058	4,629,133	5,885,729	1,711,154	1,437,143	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.03	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL	26,572,463	26,572,463				5.00
7.00	00700	OPERATION OF PLANT	5,049,516	1,377,791	6,427,307			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	387,095	105,621	29,143	521,859		8.00
9.00	00900	HOUSEKEEPING	1,589,118	433,600	68,909	0	2,091,627	9.00
10.00	01000	DIETARY	3,248,133	886,273	285,995	0	94,513	10.00
11.00	01100	CAFETERIA	-519,785	0	123,671	0	40,869	11.00
13.00	01300	NURSING ADMINISTRATION	1,499,674	409,195	13,114	0	4,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	392,692	107,148	118,054	4,989	39,013	14.00
15.00	01500	PHARMACY	11,267,238	3,074,333	73,387	301	24,252	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	550,414	150,184	140,706	0	46,499	16.00
17.00	01700	SOCIAL SERVICE	1,308,346	356,990	13,883	0	4,588	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,405,609	3,657,806	1,453,768	192,387	480,430	30.00
31.00	03100	INTENSIVE CARE UNIT	2,886,123	787,496	145,395	37,664	48,049	31.00
40.00	04000	SUBPROVIDER - IPF	1,710,471	466,712	194,673	7,524	64,334	40.00
44.00	04400	SKILLED NURSING FACILITY	2,026,291	552,886	102,423	18,047	33,848	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,915,610	1,886,966	548,544	68,682	181,277	50.00
51.00	05100	RECOVERY ROOM	785,428	214,309	89,574	8,675	29,601	51.00
53.00	05300	ANESTHESIOLOGY	388,951	106,128	6,464	0	2,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,764,139	1,027,068	289,281	26,273	95,598	54.00
56.00	05600	RADIOISOTOPE	443,310	120,960	26,520	1,170	8,764	56.00
57.00	05700	CT SCAN	824,665	225,015	15,075	8,269	4,982	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	800,292	218,364	127,353	1,169	42,086	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,052,005	287,046	46,655	7,540	15,418	59.00
60.00	06000	LABORATORY	3,746,697	1,022,309	381,000	0	125,909	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,061,012	289,503	9,644	0	3,187	63.00
65.00	06500	RESPIRATORY THERAPY	1,290,060	352,001	40,853	0	13,501	65.00
66.00	06600	PHYSICAL THERAPY	1,645,306	448,932	143,726	8,641	47,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	372,880	101,743	38,707	0	12,791	67.00
68.00	06800	SPEECH PATHOLOGY	209,151	57,068	13,247	0	4,378	68.00
69.00	06900	ELECTROCARDIOLOGY	1,469,160	400,869	133,844	92	44,231	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,129,024	580,917	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,217,385	2,242,163	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,445	45,961	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	338,770	92,435	7,418	0	2,451	74.00
76.00	03020	ONCOLOGY	1,150,856	314,018	47,079	0	15,558	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,456,499	397,414	90,660	27,502	29,960	76.01
76.02	03550	OP PSYCH	582,694	158,992	102,847	4	33,988	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	333,734	91,061	0	7,868	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,735,668	1,292,155	440,478	67,662	145,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,603,205	983,156	25,857	27,400	8,545	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,858,344	25,322,588	5,387,947	521,859	1,748,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	89,115	24,316	27,447	0	9,070	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	31,902	8,705	42,283	0	13,973	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	985,549	268,913	27,580	0	9,114	193.01
193.02	19302	MEDICAL OFFICE BUILDING	766,958	209,269	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	1,807,144	493,090	12,743	0	4,211	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	357,659	97,589	924,485	0	305,514	193.06
193.07	19307	POB 2	494,665	134,972	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	47,722	13,021	4,822	0	1,593	193.09
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	123,439,058	26,572,463	6,427,307	521,859	2,091,627	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	4,514,914					10.00
11.00	01100	CAFETERIA	2,086,169	1,730,924				11.00
13.00	01300	NURSING ADMINISTRATION	0	44,621	1,970,938			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,089	0	681,985		14.00
15.00	01500	PHARMACY	0	56,872	0	0	14,496,383	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,815	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	41,961	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	829,783	390,579	1,196,667	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	112,496	79,197	242,747	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	116,652	46,969	143,975	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	195,922	65,672	201,270	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	107,916	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	16,467	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,216	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,086	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	5,461	0	0	0	56.00
57.00	05700	CT SCAN	0	15,053	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,777	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,070	0	0	0	59.00
60.00	06000	LABORATORY	0	83,215	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,412	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	36,670	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,950	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,365	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,753	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,999	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	260,586	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	421,399	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,496,383	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	38,905	101,974	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	28,634	84,305	0	0	76.01
76.02	03550	OP PSYCH	0	21,334	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	132,419	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	146,283	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,341,022	1,674,760	1,970,938	681,985	14,496,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,914	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	1,075	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	8,545	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	20,627	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	16,071	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	948,234	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	0	6,932	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	225,658	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
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)	4,514,914	1,730,924	1,970,938	681,985	14,496,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	909,618					16.00
17.00	01700	SOCIAL SERVICE	0	1,725,768				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,794	1,167,907	22,847,730	0	22,847,730	30.00
31.00	03100	INTENSIVE CARE UNIT	17,252	147,640	4,504,059	0	4,504,059	31.00
40.00	04000	SUBPROVIDER - IPF	9,788	153,090	2,914,188	0	2,914,188	40.00
44.00	04400	SKILLED NURSING FACILITY	6,665	257,131	3,460,155	0	3,460,155	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,157	0	9,765,152	0	9,765,152	50.00
51.00	05100	RECOVERY ROOM	9,951	0	1,154,005	0	1,154,005	51.00
53.00	05300	ANESTHESIOLOGY	18,344	0	526,239	0	526,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,006	0	5,369,451	0	5,369,451	54.00
56.00	05600	RADIOISOTOPE	7,319	0	613,504	0	613,504	56.00
57.00	05700	CT SCAN	76,764	0	1,169,823	0	1,169,823	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26,339	0	1,238,380	0	1,238,380	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,434	0	1,450,168	0	1,450,168	59.00
60.00	06000	LABORATORY	90,109	0	5,449,239	0	5,449,239	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,888	0	1,387,646	0	1,387,646	63.00
65.00	06500	RESPIRATORY THERAPY	13,688	0	1,746,773	0	1,746,773	65.00
66.00	06600	PHYSICAL THERAPY	13,622	0	2,356,674	0	2,356,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,401	0	541,887	0	541,887	67.00
68.00	06800	SPEECH PATHOLOGY	1,725	0	290,322	0	290,322	68.00
69.00	06900	ELECTROCARDIOLOGY	42,440	0	2,131,635	0	2,131,635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,488	0	2,989,015	0	2,989,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,373	0	10,934,320	0	10,934,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,780	0	14,817,569	0	14,817,569	73.00
74.00	07400	RENAL DIALYSIS	2,206	0	443,280	0	443,280	74.00
76.00	03020	ONCOLOGY	6,565	0	1,674,955	0	1,674,955	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	17,865	0	2,132,839	0	2,132,839	76.01
76.02	03550	OP PSYCH	4,823	0	904,682	0	904,682	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,910	0	438,573	0	438,573	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	99,931	0	6,913,878	0	6,913,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	34,991	0	4,829,437	0	4,829,437	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	909,618	1,725,768	114,995,578	0	114,995,578	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	152,862	0	152,862	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	97,938	0	97,938	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	1,299,701	0	1,299,701	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	996,854	0	996,854	193.02
193.03	19303	HOME CARE PHARMACY	0	0	2,333,259	0	2,333,259	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	948,234	0	948,234	193.05
193.06	19306	VACANT SPACE	0	0	1,685,247	0	1,685,247	193.06
193.07	19307	POB 2	0	0	636,569	0	636,569	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	225,658	0	225,658	193.08
193.09	19309	COFFEE BAR	0	0	67,158	0	67,158	193.09
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)	909,618	1,725,768	123,439,058	0	123,439,058	202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet Non-CMS W | Date/Time Prepared: 5/24/2017 2:49 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
4.03	ADMITTING	7	GROSS REVENUE	4.03
5.00	ADMINISTRATIVE & GENERAL	-21	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	12	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	14	MEALS SERVED	10.00
11.00	CAFETERIA	15	FTE'S	11.00
13.00	NURSING ADMINISTRATION	16	HOURS OF SERVICE	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUISITIONS	14.00
15.00	PHARMACY	18	COSTED REQUISITIONS	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	20	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,613	25,214	1,711	32,538	32,538	4.00
4.03	00401	ADMITTING	6,341	55,645	7,024	69,010	758	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	681,182	260,810	4,020,034	4,962,026	2,297	5.00
7.00	00700	OPERATION OF PLANT	6,098	1,800,907	26,657	1,833,662	616	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,275	261	11,536	0	8.00
9.00	00900	HOUSEKEEPING	498	26,659	266	27,423	746	9.00
10.00	01000	DIETARY	15,623	110,644	10,467	136,734	0	10.00
11.00	01100	CAFETERIA	0	47,845	0	47,845	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,074	38,722	43,796	764	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	441	45,672	43,699	89,812	201	14.00
15.00	01500	PHARMACY	156,887	28,391	4,482	189,760	1,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,729	54,435	1,445	59,609	226	16.00
17.00	01700	SOCIAL SERVICE	2,488	5,371	2,447	10,306	793	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	439,544	562,424	121,394	1,123,362	6,639	30.00
31.00	03100	INTENSIVE CARE UNIT	3,422	56,250	65,742	125,414	1,472	31.00
40.00	04000	SUBPROVIDER - IPF	2,190	75,314	314	77,818	921	40.00
44.00	04400	SKILLED NURSING FACILITY	2,079	39,625	9,825	51,529	1,065	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,775	212,217	197,140	421,132	1,953	50.00
51.00	05100	RECOVERY ROOM	453	34,654	261	35,368	375	51.00
53.00	05300	ANESTHESIOLOGY	0	2,501	53,977	56,478	53	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,377	111,915	389,939	508,231	1,641	54.00
56.00	05600	RADIOISOTOPE	0	10,260	1,015	11,275	131	56.00
57.00	05700	CT SCAN	0	5,832	168,502	174,334	227	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,981	49,270	2,989	55,240	357	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,049	24,007	42,056	421	59.00
60.00	06000	LABORATORY	3,031	147,399	83,145	233,575	943	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,731	4,032	7,763	206	63.00
65.00	06500	RESPIRATORY THERAPY	20,656	15,805	14,031	50,492	601	65.00
66.00	06600	PHYSICAL THERAPY	3,283	55,604	15,367	74,254	844	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,975	2,610	17,585	212	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,125	0	5,125	116	68.00
69.00	06900	ELECTROCARDIOLOGY	449	51,781	68,009	120,239	736	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,870	0	2,870	0	74.00
76.00	03020	ONCOLOGY	4,815	18,213	10,164	33,192	509	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,028	35,074	127,623	163,725	640	76.01
76.02	03550	OP PSYCH	3,703	39,789	22,355	65,847	295	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,968	170,409	51,445	225,822	2,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	620	10,004	290,668	301,292	1,540	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,389,274	4,227,032	5,881,769	11,498,075	31,834	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,619	1,641	12,260	23	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	16,358	302	16,660	8	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	326	10,670	1,322	12,318	156	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	0	0	197	193.02
193.03	19303	HOME CARE PHARMACY	228	4,930	695	5,853	263	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	357,659	0	357,659	0	193.06
193.07	19307	POB 2	0	0	0	0	57	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	1,865	0	1,865	0	193.09
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)	1,389,828	4,629,133	5,885,729	11,904,690	32,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	ADMITTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.03	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING	69,768					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,964,323				5.00
7.00	00700	OPERATION OF PLANT	0	257,404	2,091,682			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,733	9,484	40,753		8.00
9.00	00900	HOUSEKEEPING	0	81,007	22,426	0	131,602	9.00
10.00	01000	DIETARY	0	165,577	93,073	0	5,947	10.00
11.00	01100	CAFETERIA	0	0	40,247	0	2,571	11.00
13.00	01300	NURSING ADMINISTRATION	0	76,447	4,268	0	273	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,018	38,419	390	2,455	14.00
15.00	01500	PHARMACY	0	574,359	23,883	24	1,526	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,058	45,791	0	2,926	16.00
17.00	01700	SOCIAL SERVICE	0	66,694	4,518	0	289	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,591	683,321	473,109	15,024	30,229	30.00
31.00	03100	INTENSIVE CARE UNIT	1,325	147,123	47,317	2,941	3,023	31.00
40.00	04000	SUBPROVIDER - IPF	752	87,193	63,354	588	4,048	40.00
44.00	04400	SKILLED NURSING FACILITY	512	103,292	33,332	1,409	2,130	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,313	352,530	178,516	5,363	11,406	50.00
51.00	05100	RECOVERY ROOM	764	40,038	29,151	677	1,862	51.00
53.00	05300	ANESTHESIOLOGY	1,409	19,827	2,104	0	134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,762	191,881	94,143	2,052	6,015	54.00
56.00	05600	RADIOISOTOPE	562	22,598	8,631	91	551	56.00
57.00	05700	CT SCAN	5,895	42,038	4,906	646	313	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,023	40,796	41,445	91	2,648	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,493	53,627	15,183	589	970	59.00
60.00	06000	LABORATORY	6,920	190,992	123,992	0	7,922	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	836	54,086	3,138	0	201	63.00
65.00	06500	RESPIRATORY THERAPY	1,051	65,762	13,295	0	849	65.00
66.00	06600	PHYSICAL THERAPY	1,046	83,871	46,774	675	2,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	261	19,008	12,597	0	805	67.00
68.00	06800	SPEECH PATHOLOGY	133	10,662	4,311	0	275	68.00
69.00	06900	ELECTROCARDIOLOGY	3,259	74,892	43,558	7	2,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,420	108,529	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,099	418,889	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,111	8,587	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	169	17,269	2,414	0	154	74.00
76.00	03020	ONCOLOGY	504	58,666	15,321	0	979	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,372	74,246	29,504	2,148	1,885	76.01
76.02	03550	OP PSYCH	370	29,703	33,470	0	2,138	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	454	17,012	0	614	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,675	241,405	143,348	5,284	9,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,687	183,677	8,415	2,140	538	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,768	4,730,817	1,753,437	40,753	109,992	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,543	8,932	0	571	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	1,626	13,761	0	879	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	50,239	8,975	0	573	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	39,096	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	92,121	4,147	0	265	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	18,232	300,861	0	19,222	193.06
193.07	19307	POB 2	0	25,216	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	2,433	1,569	0	100	193.09
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)	69,768	4,964,323	2,091,682	40,753	131,602	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	401,331					10.00
11.00	01100	CAFETERIA	185,438	207,917				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,360	130,908			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,413	0	153,708		14.00
15.00	01500	PHARMACY	0	6,831	0	0	797,681	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,620	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,040	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,760	46,917	79,482	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,000	9,513	16,123	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	10,369	5,642	9,563	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	17,416	7,888	13,368	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,963	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,978	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	506	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,623	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	656	0	0	0	56.00
57.00	05700	CT SCAN	0	1,808	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,736	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,651	0	0	0	59.00
60.00	06000	LABORATORY	0	9,996	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,611	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,405	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,880	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,485	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	571	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,925	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	58,732	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	94,976	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	797,681	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	4,673	6,773	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	3,440	5,599	0	0	76.01
76.02	03550	OP PSYCH	0	2,563	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	15,906	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,571	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	296,983	201,171	130,908	153,708	797,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	350	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	129	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	1,026	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	2,478	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	1,930	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	84,289	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	0	833	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	20,059	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	68,184	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	401,331	276,101	130,908	153,708	797,681	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,230					16.00
17.00	01700	SOCIAL SERVICE	0	87,640				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,142	59,310	2,607,886	0	2,607,886	30.00
31.00	03100	INTENSIVE CARE UNIT	2,641	7,498	374,390	0	374,390	31.00
40.00	04000	SUBPROVIDER - IPF	1,498	7,774	269,520	0	269,520	40.00
44.00	04400	SKILLED NURSING FACILITY	1,020	13,058	246,019	0	246,019	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,596	0	996,772	0	996,772	50.00
51.00	05100	RECOVERY ROOM	1,523	0	111,736	0	111,736	51.00
53.00	05300	ANESTHESIOLOGY	2,808	0	83,319	0	83,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,491	0	830,839	0	830,839	54.00
56.00	05600	RADIOISOTOPE	1,120	0	45,615	0	45,615	56.00
57.00	05700	CT SCAN	11,750	0	241,917	0	241,917	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,032	0	149,368	0	149,368	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,975	0	119,965	0	119,965	59.00
60.00	06000	LABORATORY	13,793	0	588,133	0	588,133	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,667	0	69,508	0	69,508	63.00
65.00	06500	RESPIRATORY THERAPY	2,095	0	138,550	0	138,550	65.00
66.00	06600	PHYSICAL THERAPY	2,085	0	218,417	0	218,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	521	0	52,474	0	52,474	67.00
68.00	06800	SPEECH PATHOLOGY	264	0	21,457	0	21,457	68.00
69.00	06900	ELECTROCARDIOLOGY	6,496	0	256,895	0	256,895	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,830	0	171,511	0	171,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,170	0	526,134	0	526,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,341	0	830,720	0	830,720	73.00
74.00	07400	RENAL DIALYSIS	338	0	23,214	0	23,214	74.00
76.00	03020	ONCOLOGY	1,005	0	121,622	0	121,622	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,734	0	285,293	0	285,293	76.01
76.02	03550	OP PSYCH	738	0	135,124	0	135,124	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	905	0	18,985	0	18,985	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,296	0	666,133	0	666,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,356	0	523,216	0	523,216	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	139,230	87,640	10,724,732	0	10,724,732	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	26,679	0	26,679	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	33,063	0	33,063	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	73,287	0	73,287	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	41,771	0	41,771	193.02
193.03	19303	HOME CARE PHARMACY	0	0	104,579	0	104,579	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	84,289	0	84,289	193.05
193.06	19306	VACANT SPACE	0	0	695,974	0	695,974	193.06
193.07	19307	POB 2	0	0	26,106	0	26,106	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	20,059	0	20,059	193.08
193.09	19309	COFFEE BAR	0	0	5,967	0	5,967	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	68,184	0	68,184	201.00
202.00		TOTAL (sum lines 118-201)	139,230	87,640	11,904,690	0	11,904,690	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	CAPITAL RELATED COSTS: NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS: NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
			1.00	2.00	4.00	4.03	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	451,642					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		5,918,918				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,460	1,721	43,375,529			4.00
4.03	00401	ADMITTING	5,429	7,064	1,011,036	485,104,119		4.03
5.00	00500	ADMINISTRATIVE & GENERAL	25,446	4,042,705	3,062,805	0	-26,572,463	5.00
7.00	00700	OPERATION OF PLANT	175,706	26,807	821,832	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,100	262	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,601	267	995,113	0	0	9.00
10.00	01000	DIETARY	10,795	10,526	0	0	0	10.00
11.00	01100	CAFETERIA	4,668	0	0	0	519,785	11.00
13.00	01300	NURSING ADMINISTRATION	495	38,940	1,018,120	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,456	43,945	268,476	0	0	14.00
15.00	01500	PHARMACY	2,770	4,507	1,731,322	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,311	1,453	301,762	0	0	16.00
17.00	01700	SOCIAL SERVICE	524	2,461	1,057,259	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,873	122,078	8,844,473	38,823,428	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,488	66,113	1,962,157	9,200,809	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,348	316	1,227,440	5,220,226	0	40.00
44.00	04400	SKILLED NURSING FACILITY	3,866	9,880	1,419,876	3,554,631	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,705	198,252	2,603,882	29,950,252	0	50.00
51.00	05100	RECOVERY ROOM	3,381	262	499,528	5,307,349	0	51.00
53.00	05300	ANESTHESIOLOGY	244	54,281	71,288	9,783,272	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,919	392,138	2,188,014	33,069,924	0	54.00
56.00	05600	RADIOISOTOPE	1,001	1,021	174,612	3,903,709	0	56.00
57.00	05700	CT SCAN	569	169,452	302,347	40,940,539	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,807	3,006	476,284	14,047,245	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,761	24,142	561,972	10,364,878	0	59.00
60.00	06000	LABORATORY	14,381	83,614	1,256,710	48,058,064	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	364	4,055	274,598	5,806,927	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,542	14,110	801,145	7,300,208	0	65.00
66.00	06600	PHYSICAL THERAPY	5,425	15,454	1,125,259	7,264,897	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,461	2,625	283,182	1,813,843	0	67.00
68.00	06800	SPEECH PATHOLOGY	500	0	154,663	920,215	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,052	68,392	981,593	22,634,401	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,860,350	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	28,465,644	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,924,624	0	73.00
74.00	07400	RENAL DIALYSIS	280	0	0	1,176,658	0	74.00
76.00	03020	ONCOLOGY	1,777	10,221	678,647	3,501,534	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	3,422	128,343	852,896	9,527,812	0	76.01
76.02	03550	OP PSYCH	3,882	22,481	392,834	2,572,030	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	3,152,198	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	16,626	51,735	2,983,708	53,296,558	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	976	292,307	2,053,163	18,661,894	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	412,411	5,914,936	42,437,996	485,104,119	-26,052,678	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,036	1,650	30,676	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	1,596	304	10,184	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,041	1,329	207,458	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	262,308	0	0	193.02
193.03	19303	HOME CARE PHARMACY	481	699	350,915	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	34,895	0	0	0	0	193.06
193.07	19307	POB 2	0	0	75,992	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	182	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
			1.00	2.00	4.00	4.03	5A	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,629,133	5,885,729	1,711,154	1,437,143		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.249563	0.994393	0.039450	0.002963		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			32,538	69,768		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000750	0.000144		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL	97,386,380					5.00
7.00	00700	OPERATION OF PLANT	5,049,516	242,601				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	387,095	1,100	629,324			8.00
9.00	00900	HOUSEKEEPING	1,589,118	2,601	0	238,900		9.00
10.00	01000	DIETARY	3,248,133	10,795	0	10,795	338,892	10.00
11.00	01100	CAFETERIA	0	4,668	0	4,668	156,589	11.00
13.00	01300	NURSING ADMINISTRATION	1,499,674	495	0	495	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	392,692	4,456	6,016	4,456	0	14.00
15.00	01500	PHARMACY	11,267,238	2,770	363	2,770	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	550,414	5,311	0	5,311	0	16.00
17.00	01700	SOCIAL SERVICE	1,308,346	524	0	524	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,405,609	54,873	232,005	54,873	62,284	30.00
31.00	03100	INTENSIVE CARE UNIT	2,886,123	5,488	45,420	5,488	8,444	31.00
40.00	04000	SUBPROVIDER - IPF	1,710,471	7,348	9,074	7,348	8,756	40.00
44.00	04400	SKILLED NURSING FACILITY	2,026,291	3,866	21,763	3,866	14,706	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,915,610	20,705	82,825	20,705	0	50.00
51.00	05100	RECOVERY ROOM	785,428	3,381	10,461	3,381	0	51.00
53.00	05300	ANESTHESIOLOGY	388,951	244	0	244	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,764,139	10,919	31,683	10,919	0	54.00
56.00	05600	RADIOISOTOPE	443,310	1,001	1,411	1,001	0	56.00
57.00	05700	CT SCAN	824,665	569	9,972	569	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	800,292	4,807	1,410	4,807	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,052,005	1,761	9,093	1,761	0	59.00
60.00	06000	LABORATORY	3,746,697	14,381	0	14,381	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,061,012	364	0	364	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,290,060	1,542	0	1,542	0	65.00
66.00	06600	PHYSICAL THERAPY	1,645,306	5,425	10,421	5,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	372,880	1,461	0	1,461	0	67.00
68.00	06800	SPEECH PATHOLOGY	209,151	500	0	500	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,469,160	5,052	111	5,052	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,129,024	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,217,385	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,445	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	338,770	280	0	280	0	74.00
76.00	03020	ONCOLOGY	1,150,856	1,777	0	1,777	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,456,499	3,422	33,166	3,422	0	76.01
76.02	03550	OP PSYCH	582,694	3,882	5	3,882	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	333,734	0	9,488	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,735,668	16,626	81,595	16,626	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,603,205	976	33,042	976	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,805,666	203,370	629,324	199,669	250,779	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	89,115	1,036	0	1,036	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	31,902	1,596	0	1,596	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	985,549	1,041	0	1,041	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	766,958	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	1,807,144	481	0	481	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	71,175	193.05
193.06	19306	VACANT SPACE	357,659	34,895	0	34,895	0	193.06
193.07	19307	POB 2	494,665	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	16,938	193.08
193.09	19309	COFFEE BAR	47,722	182	0	182	0	193.09
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)	26,572,463	6,427,307	521,859	2,091,627	4,514,914	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.272856	26.493324	0.829237	8.755241	13.322575	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	4,964,323	2,091,682	40,753	131,602	401,331	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.050976	8.621902	0.064757	0.550866	1.184245	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	61,175					11.00
13.00	01300	NURSING ADMINISTRATION	1,577	474,516				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	710	0	10,000			14.00
15.00	01500	PHARMACY	2,010	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	771	0	0	0	485,104,119	16.00
17.00	01700	SOCIAL SERVICE	1,483	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,804	288,105	0	0	38,823,428	30.00
31.00	03100	INTENSIVE CARE UNIT	2,799	58,443	0	0	9,200,809	31.00
40.00	04000	SUBPROVIDER - IPF	1,660	34,663	0	0	5,220,226	40.00
44.00	04400	SKILLED NURSING FACILITY	2,321	48,457	0	0	3,554,631	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,814	0	0	0	29,950,252	50.00
51.00	05100	RECOVERY ROOM	582	0	0	0	5,307,349	51.00
53.00	05300	ANESTHESIOLOGY	149	0	0	0	9,783,272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,714	0	0	0	33,069,924	54.00
56.00	05600	RADIOISOTOPE	193	0	0	0	3,903,709	56.00
57.00	05700	CT SCAN	532	0	0	0	40,940,539	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	805	0	0	0	14,047,245	58.00
59.00	05900	CARDIAC CATHETERIZATION	780	0	0	0	10,364,878	59.00
60.00	06000	LABORATORY	2,941	0	0	0	48,058,064	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	474	0	0	0	5,806,927	63.00
65.00	06500	RESPIRATORY THERAPY	1,296	0	0	0	7,300,208	65.00
66.00	06600	PHYSICAL THERAPY	1,730	0	0	0	7,264,897	66.00
67.00	06700	OCCUPATIONAL THERAPY	437	0	0	0	1,813,843	67.00
68.00	06800	SPEECH PATHOLOGY	168	0	0	0	920,215	68.00
69.00	06900	ELECTROCARDIOLOGY	1,449	0	0	0	22,634,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,821	0	9,860,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	6,179	0	28,465,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	56,924,624	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,176,658	74.00
76.00	03020	ONCOLOGY	1,375	24,551	0	0	3,501,534	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,012	20,297	0	0	9,527,812	76.01
76.02	03550	OP PSYCH	754	0	0	0	2,572,030	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	3,152,198	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,680	0	0	0	53,296,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,170	0	0	0	18,661,894	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,190	474,516	10,000	100	485,104,119	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	103	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	38	0	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	302	0	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	729	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	568	0	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	245	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
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)	1,730,924	1,970,938	681,985	14,496,383	909,618	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.294630	4.153575	68.198500	144,963.830000	0.001875	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	276,101	130,908	153,708	797,681	139,230	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.398725	0.275877	15.370800	7,976.810000	0.000287	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS) 17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
4.03	00401	ADMITTING			4.03
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	31,350		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	21,216		30.00
31.00	03100	INTENSIVE CARE UNIT	2,682		31.00
40.00	04000	SUBPROVIDER - IPF	2,781		40.00
44.00	04400	SKILLED NURSING FACILITY	4,671		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03020	ONCOLOGY	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0		76.01
76.02	03550	OP PSYCH	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,350		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01	19201	TWIN RIVERS MRI	0		192.01
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0		193.01
193.02	19302	MEDICAL OFFICE BUILDING	0		193.02
193.03	19303	HOME CARE PHARMACY	0		193.03
193.04	19304	MANAGEMENT SERVICES	0		193.04
193.05	19305	EUNICE SMITH NURSING HOME	0		193.05
193.06	19306	VACANT SPACE	0		193.06
193.07	19307	POB 2	0		193.07
193.08	19308	NON REIMBURSABLE MEALS	0		193.08
193.09	19309	COFFEE BAR	0		193.09
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)	1,725,768		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.048421		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,640		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 2:49 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	2.795534		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 2:49 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	22,847,730		22,847,730	0	22,847,730	30.00
31.00	03100	INTENSIVE CARE UNIT	4,504,059		4,504,059	0	4,504,059	31.00
40.00	04000	SUBPROVIDER - IPF	2,914,188		2,914,188	0	2,914,188	40.00
44.00	04400	SKILLED NURSING FACILITY	3,460,155		3,460,155	0	3,460,155	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,765,152		9,765,152	0	9,765,152	50.00
51.00	05100	RECOVERY ROOM	1,154,005		1,154,005	0	1,154,005	51.00
53.00	05300	ANESTHESIOLOGY	526,239		526,239	0	526,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,369,451		5,369,451	0	5,369,451	54.00
56.00	05600	RADIOISOTOPE	613,504		613,504	0	613,504	56.00
57.00	05700	CT SCAN	1,169,823		1,169,823	0	1,169,823	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,238,380		1,238,380	0	1,238,380	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,450,168		1,450,168	0	1,450,168	59.00
60.00	06000	LABORATORY	5,449,239		5,449,239	0	5,449,239	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,387,646		1,387,646	0	1,387,646	63.00
65.00	06500	RESPIRATORY THERAPY	1,746,773	0	1,746,773	0	1,746,773	65.00
66.00	06600	PHYSICAL THERAPY	2,356,674	0	2,356,674	0	2,356,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	541,887	0	541,887	0	541,887	67.00
68.00	06800	SPEECH PATHOLOGY	290,322	0	290,322	0	290,322	68.00
69.00	06900	ELECTROCARDIOLOGY	2,131,635		2,131,635	0	2,131,635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,989,015		2,989,015	0	2,989,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,934,320		10,934,320	0	10,934,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,817,569		14,817,569	0	14,817,569	73.00
74.00	07400	RENAL DIALYSIS	443,280		443,280	0	443,280	74.00
76.00	03020	ONCOLOGY	1,674,955		1,674,955	0	1,674,955	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,132,839		2,132,839	0	2,132,839	76.01
76.02	03550	OP PSYCH	904,682		904,682	0	904,682	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	438,573		438,573	0	438,573	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,913,878		6,913,878	0	6,913,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,701,401		1,701,401		1,701,401	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,829,437		4,829,437	0	4,829,437	95.00
200.00		Subtotal (see instructions)	116,696,979	0	116,696,979	0	116,696,979	200.00
201.00		Less Observation Beds	1,701,401		1,701,401		1,701,401	201.00
202.00		Total (see instructions)	114,995,578	0	114,995,578	0	114,995,578	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 2:49 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	37,307,643		37,307,643			30.00
31.00	03100	INTENSIVE CARE UNIT	9,200,809		9,200,809			31.00
40.00	04000	SUBPROVIDER - IPF	5,220,226		5,220,226			40.00
44.00	04400	SKILLED NURSING FACILITY	3,554,631		3,554,631			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,906,799	21,043,453	29,950,252	0.326046	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,074,189	4,233,160	5,307,349	0.217435	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,530,267	6,253,005	9,783,272	0.053790	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,982,788	28,087,136	33,069,924	0.162367	0.000000	54.00
56.00	05600	RADIOISOTOPE	849,729	3,053,980	3,903,709	0.157159	0.000000	56.00
57.00	05700	CT SCAN	9,598,040	31,342,499	40,940,539	0.028574	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,557,128	12,490,117	14,047,245	0.088158	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,125,332	6,239,546	10,364,878	0.139912	0.000000	59.00
60.00	06000	LABORATORY	19,798,322	28,259,742	48,058,064	0.113389	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,308,789	2,498,138	5,806,927	0.238964	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,423,147	877,061	7,300,208	0.239277	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,321,426	4,943,471	7,264,897	0.324392	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,211,750	602,093	1,813,843	0.298751	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	223,077	697,138	920,215	0.315494	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,332,904	15,301,497	22,634,401	0.094177	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,812,747	6,047,603	9,860,350	0.303135	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,645,556	11,820,088	28,465,644	0.384123	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,127,380	36,797,244	56,924,624	0.260302	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,141,798	34,860	1,176,658	0.376728	0.000000	74.00
76.00	03020	ONCOLOGY	27,899	3,473,635	3,501,534	0.478349	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,151,046	8,376,766	9,527,812	0.223854	0.000000	76.01
76.02	03550	OP PSYCH	6,275	2,565,755	2,572,030	0.351739	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	16,436	3,135,762	3,152,198	0.139132	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,676,384	42,620,174	53,296,558	0.129725	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	261,670	1,254,115	1,515,785	1.122455	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,825	18,658,069	18,661,894	0.258786	0.000000	95.00
200.00		Subtotal (see instructions)	184,398,012	300,706,107	485,104,119			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	184,398,012	300,706,107	485,104,119			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 2:49 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
40.00	04000	SUBPROVIDER - IPF			40.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.326046		50.00
51.00	05100	RECOVERY ROOM	0.217435		51.00
53.00	05300	ANESTHESIOLOGY	0.053790		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367		54.00
56.00	05600	RADIOISOTOPE	0.157159		56.00
57.00	05700	CT SCAN	0.028574		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912		59.00
60.00	06000	LABORATORY	0.113389		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964		63.00
65.00	06500	RESPIRATORY THERAPY	0.239277		65.00
66.00	06600	PHYSICAL THERAPY	0.324392		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751		67.00
68.00	06800	SPEECH PATHOLOGY	0.315494		68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302		73.00
74.00	07400	RENAL DIALYSIS	0.376728		74.00
76.00	03020	ONCOLOGY	0.478349		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854		76.01
76.02	03550	OP PSYCH	0.351739		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132		76.98
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.129725		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.258786		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 2:49 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	22,847,730		22,847,730	0	22,847,730	30.00
31.00	03100	INTENSIVE CARE UNIT	4,504,059		4,504,059	0	4,504,059	31.00
40.00	04000	SUBPROVIDER - IPF	2,914,188		2,914,188	0	2,914,188	40.00
44.00	04400	SKILLED NURSING FACILITY	3,460,155		3,460,155	0	3,460,155	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,765,152		9,765,152	0	9,765,152	50.00
51.00	05100	RECOVERY ROOM	1,154,005		1,154,005	0	1,154,005	51.00
53.00	05300	ANESTHESIOLOGY	526,239		526,239	0	526,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,369,451		5,369,451	0	5,369,451	54.00
56.00	05600	RADIOISOTOPE	613,504		613,504	0	613,504	56.00
57.00	05700	CT SCAN	1,169,823		1,169,823	0	1,169,823	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,238,380		1,238,380	0	1,238,380	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,450,168		1,450,168	0	1,450,168	59.00
60.00	06000	LABORATORY	5,449,239		5,449,239	0	5,449,239	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,387,646		1,387,646	0	1,387,646	63.00
65.00	06500	RESPIRATORY THERAPY	1,746,773	0	1,746,773	0	1,746,773	65.00
66.00	06600	PHYSICAL THERAPY	2,356,674	0	2,356,674	0	2,356,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	541,887	0	541,887	0	541,887	67.00
68.00	06800	SPEECH PATHOLOGY	290,322	0	290,322	0	290,322	68.00
69.00	06900	ELECTROCARDIOLOGY	2,131,635		2,131,635	0	2,131,635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,989,015		2,989,015	0	2,989,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,934,320		10,934,320	0	10,934,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,817,569		14,817,569	0	14,817,569	73.00
74.00	07400	RENAL DIALYSIS	443,280		443,280	0	443,280	74.00
76.00	03020	ONCOLOGY	1,674,955		1,674,955	0	1,674,955	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,132,839		2,132,839	0	2,132,839	76.01
76.02	03550	OP PSYCH	904,682		904,682	0	904,682	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	438,573		438,573	0	438,573	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,913,878		6,913,878	0	6,913,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,701,401		1,701,401		1,701,401	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,829,437		4,829,437	0	4,829,437	95.00
200.00		Subtotal (see instructions)	116,696,979	0	116,696,979	0	116,696,979	200.00
201.00		Less Observation Beds	1,701,401		1,701,401		1,701,401	201.00
202.00		Total (see instructions)	114,995,578	0	114,995,578	0	114,995,578	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 2:49 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	37,307,643		37,307,643			30.00
31.00	03100	INTENSIVE CARE UNIT	9,200,809		9,200,809			31.00
40.00	04000	SUBPROVIDER - IPF	5,220,226		5,220,226			40.00
44.00	04400	SKILLED NURSING FACILITY	3,554,631		3,554,631			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,906,799	21,043,453	29,950,252	0.326046	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,074,189	4,233,160	5,307,349	0.217435	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,530,267	6,253,005	9,783,272	0.053790	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,982,788	28,087,136	33,069,924	0.162367	0.000000	54.00
56.00	05600	RADIOISOTOPE	849,729	3,053,980	3,903,709	0.157159	0.000000	56.00
57.00	05700	CT SCAN	9,598,040	31,342,499	40,940,539	0.028574	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,557,128	12,490,117	14,047,245	0.088158	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,125,332	6,239,546	10,364,878	0.139912	0.000000	59.00
60.00	06000	LABORATORY	19,798,322	28,259,742	48,058,064	0.113389	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,308,789	2,498,138	5,806,927	0.238964	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,423,147	877,061	7,300,208	0.239277	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,321,426	4,943,471	7,264,897	0.324392	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,211,750	602,093	1,813,843	0.298751	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	223,077	697,138	920,215	0.315494	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,332,904	15,301,497	22,634,401	0.094177	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,812,747	6,047,603	9,860,350	0.303135	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,645,556	11,820,088	28,465,644	0.384123	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,127,380	36,797,244	56,924,624	0.260302	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,141,798	34,860	1,176,658	0.376728	0.000000	74.00
76.00	03020	ONCOLOGY	27,899	3,473,635	3,501,534	0.478349	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,151,046	8,376,766	9,527,812	0.223854	0.000000	76.01
76.02	03550	OP PSYCH	6,275	2,565,755	2,572,030	0.351739	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	16,436	3,135,762	3,152,198	0.139132	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,676,384	42,620,174	53,296,558	0.129725	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	261,670	1,254,115	1,515,785	1.122455	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,825	18,658,069	18,661,894	0.258786	0.000000	95.00
200.00		Subtotal (see instructions)	184,398,012	300,706,107	485,104,119			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	184,398,012	300,706,107	485,104,119			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 2:49 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
40.00	04000	SUBPROVIDER - IPF			40.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.326046		50.00
51.00	05100	RECOVERY ROOM	0.217435		51.00
53.00	05300	ANESTHESIOLOGY	0.053790		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367		54.00
56.00	05600	RADIOISOTOPE	0.157159		56.00
57.00	05700	CT SCAN	0.028574		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912		59.00
60.00	06000	LABORATORY	0.113389		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964		63.00
65.00	06500	RESPIRATORY THERAPY	0.239277		65.00
66.00	06600	PHYSICAL THERAPY	0.324392		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751		67.00
68.00	06800	SPEECH PATHOLOGY	0.315494		68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302		73.00
74.00	07400	RENAL DIALYSIS	0.376728		74.00
76.00	03020	ONCOLOGY	0.478349		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854		76.01
76.02	03550	OP PSYCH	0.351739		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132		76.98
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.129725		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.258786		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II | Date/Time Prepared: 5/24/2017 2:49 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	9,765,152	996,772	8,768,380	0	0	50.00
51.00	05100	RECOVERY ROOM	1,154,005	111,736	1,042,269	0	0	51.00
53.00	05300	ANESTHESIOLOGY	526,239	83,319	442,920	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,369,451	830,839	4,538,612	0	0	54.00
56.00	05600	RADIOISOTOPE	613,504	45,615	567,889	0	0	56.00
57.00	05700	CT SCAN	1,169,823	241,917	927,906	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,238,380	149,368	1,089,012	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,450,168	119,965	1,330,203	0	0	59.00
60.00	06000	LABORATORY	5,449,239	588,133	4,861,106	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,387,646	69,508	1,318,138	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,746,773	138,550	1,608,223	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,356,674	218,417	2,138,257	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	541,887	52,474	489,413	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	290,322	21,457	268,865	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,131,635	256,895	1,874,740	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,989,015	171,511	2,817,504	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,934,320	526,134	10,408,186	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,817,569	830,720	13,986,849	0	0	73.00
74.00	07400	RENAL DIALYSIS	443,280	23,214	420,066	0	0	74.00
76.00	03020	ONCOLOGY	1,674,955	121,622	1,553,333	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,132,839	285,293	1,847,546	0	0	76.01
76.02	03550	OP PSYCH	904,682	135,124	769,558	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	438,573	18,985	419,588	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,913,878	666,133	6,247,745	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,701,401	194,201	1,507,200	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,829,437	523,216	4,306,221	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	82,970,847	7,421,118	75,549,729	0	0	200.00
201.00		Less Observation Beds	1,701,401	194,201	1,507,200	0	0	201.00
202.00		Total (line 200 minus line 201)	81,269,446	7,226,917	74,042,529	0	0	202.00

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

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II | Date/Time Prepared: 5/24/2017 2:49 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	9,765,152	29,950,252	0.326046		50.00
51.00	05100	RECOVERY ROOM	1,154,005	5,307,349	0.217435		51.00
53.00	05300	ANESTHESIOLOGY	526,239	9,783,272	0.053790		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,369,451	33,069,924	0.162367		54.00
56.00	05600	RADIOISOTOPE	613,504	3,903,709	0.157159		56.00
57.00	05700	CT SCAN	1,169,823	40,940,539	0.028574		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,238,380	14,047,245	0.088158		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,450,168	10,364,878	0.139912		59.00
60.00	06000	LABORATORY	5,449,239	48,058,064	0.113389		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,387,646	5,806,927	0.238964		63.00
65.00	06500	RESPIRATORY THERAPY	1,746,773	7,300,208	0.239277		65.00
66.00	06600	PHYSICAL THERAPY	2,356,674	7,264,897	0.324392		66.00
67.00	06700	OCCUPATIONAL THERAPY	541,887	1,813,843	0.298751		67.00
68.00	06800	SPEECH PATHOLOGY	290,322	920,215	0.315494		68.00
69.00	06900	ELECTROCARDIOLOGY	2,131,635	22,634,401	0.094177		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,989,015	9,860,350	0.303135		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,934,320	28,465,644	0.384123		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,817,569	56,924,624	0.260302		73.00
74.00	07400	RENAL DIALYSIS	443,280	1,176,658	0.376728		74.00
76.00	03020	ONCOLOGY	1,674,955	3,501,534	0.478349		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,132,839	9,527,812	0.223854		76.01
76.02	03550	OP PSYCH	904,682	2,572,030	0.351739		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	438,573	3,152,198	0.139132		76.98
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	6,913,878	53,296,558	0.129725		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,701,401	1,515,785	1.122455		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	4,829,437	18,661,894	0.258786		95.00
200.00		Subtotal (sum of lines 50 thru 199)	82,970,847	429,820,810			200.00
201.00		Less Observation Beds	1,701,401	0			201.00
202.00		Total (line 200 minus line 201)	81,269,446	429,820,810			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I | Date/Time Prepared: 5/24/2017 2:49 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	2,607,886	0	2,607,886	22,923	113.77	30.00
31.00	INTENSIVE CARE UNIT	374,390		374,390	2,682	139.59	31.00
40.00	SUBPROVIDER - IPF	269,520	0	269,520	2,781	96.91	40.00
44.00	SKILLED NURSING FACILITY	246,019		246,019	4,671	52.67	44.00
200.00	Total (lines 30-199)	3,497,815		3,497,815	33,057		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	9,532	1,084,456	30.00
31.00	INTENSIVE CARE UNIT	1,228	171,417	31.00
40.00	SUBPROVIDER - IPF	2,500	242,275	40.00
44.00	SKILLED NURSING FACILITY	2,773	146,054	44.00
200.00	Total (lines 30-199)	16,033	1,644,202	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/24/2017 2:49 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	996,772	29,950,252	0.033281	4,494,414	149,579	50.00
51.00	05100	RECOVERY ROOM	111,736	5,307,349	0.021053	479,812	10,101	51.00
53.00	05300	ANESTHESIOLOGY	83,319	9,783,272	0.008516	1,499,701	12,771	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,839	33,069,924	0.025124	1,968,845	49,465	54.00
56.00	05600	RADIOISOTOPE	45,615	3,903,709	0.011685	336,486	3,932	56.00
57.00	05700	CT SCAN	241,917	40,940,539	0.005909	4,611,424	27,249	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,368	14,047,245	0.010633	763,646	8,120	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,965	10,364,878	0.011574	1,140,064	13,195	59.00
60.00	06000	LABORATORY	588,133	48,058,064	0.012238	9,480,647	116,024	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69,508	5,806,927	0.011970	765,305	9,161	63.00
65.00	06500	RESPIRATORY THERAPY	138,550	7,300,208	0.018979	3,244,628	61,580	65.00
66.00	06600	PHYSICAL THERAPY	218,417	7,264,897	0.030065	683,589	20,552	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,474	1,813,843	0.028930	192,445	5,567	67.00
68.00	06800	SPEECH PATHOLOGY	21,457	920,215	0.023317	122,512	2,857	68.00
69.00	06900	ELECTROCARDIOLOGY	256,895	22,634,401	0.011350	4,711,976	53,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,511	9,860,350	0.017394	1,979,467	34,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	526,134	28,465,644	0.018483	7,309,653	135,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	830,720	56,924,624	0.014593	10,729,935	156,582	73.00
74.00	07400	RENAL DIALYSIS	23,214	1,176,658	0.019729	661,998	13,061	74.00
76.00	03020	ONCOLOGY	121,622	3,501,534	0.034734	8,874	308	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	285,293	9,527,812	0.029943	470,741	14,095	76.01
76.02	03550	OP PSYCH	135,124	2,572,030	0.052536	2,542	134	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	18,985	3,152,198	0.006023	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	666,133	53,296,558	0.012499	3,624,022	45,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	194,201	1,515,785	0.128119	132,204	16,938	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,897,902	411,158,916		59,414,930	959,584	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/24/2017 2:49 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,923	0.00	9,532	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,682	0.00	1,228	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,781	0.00	2,500	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	4,671	0.00	2,773	0	0	44.00
200.00		Total (lines 30-199)	33,057		16,033	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 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	29,950,252	0.000000	0.000000	4,494,414	50.00
51.00	05100	RECOVERY ROOM	0	5,307,349	0.000000	0.000000	479,812	51.00
53.00	05300	ANESTHESIOLOGY	0	9,783,272	0.000000	0.000000	1,499,701	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,069,924	0.000000	0.000000	1,968,845	54.00
56.00	05600	RADIOISOTOPE	0	3,903,709	0.000000	0.000000	336,486	56.00
57.00	05700	CT SCAN	0	40,940,539	0.000000	0.000000	4,611,424	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,047,245	0.000000	0.000000	763,646	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,364,878	0.000000	0.000000	1,140,064	59.00
60.00	06000	LABORATORY	0	48,058,064	0.000000	0.000000	9,480,647	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	5,806,927	0.000000	0.000000	765,305	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,300,208	0.000000	0.000000	3,244,628	65.00
66.00	06600	PHYSICAL THERAPY	0	7,264,897	0.000000	0.000000	683,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,813,843	0.000000	0.000000	192,445	67.00
68.00	06800	SPEECH PATHOLOGY	0	920,215	0.000000	0.000000	122,512	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,634,401	0.000000	0.000000	4,711,976	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,860,350	0.000000	0.000000	1,979,467	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	28,465,644	0.000000	0.000000	7,309,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,924,624	0.000000	0.000000	10,729,935	73.00
74.00	07400	RENAL DIALYSIS	0	1,176,658	0.000000	0.000000	661,998	74.00
76.00	03020	ONCOLOGY	0	3,501,534	0.000000	0.000000	8,874	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	9,527,812	0.000000	0.000000	470,741	76.01
76.02	03550	OP PSYCH	0	2,572,030	0.000000	0.000000	2,542	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,152,198	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	53,296,558	0.000000	0.000000	3,624,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,515,785	0.000000	0.000000	132,204	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	411,158,916			59,414,930	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,617,190	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,116,859	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,406,538	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,702,796	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	1,113,153	0	0	0	56.00
57.00	05700	CT SCAN	0	9,883,706	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,895,637	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,269,736	0	0	0	59.00
60.00	06000	LABORATORY	0	5,420,497	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	284,950	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	238,754	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,882	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,738	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	438	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,061,237	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,478,063	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,319,592	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,807,698	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	624,531	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	2,325,830	0	0	0	76.01
76.02	03550	OP PSYCH	0	2,056,353	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,500,504	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	6,653,495	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	403,855	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	81,199,032	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 2:49 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	0.326046	7,617,190	0	0	2,483,554	50.00
51.00	05100	RECOVERY ROOM	0.217435	1,116,859	0	0	242,844	51.00
53.00	05300	ANESTHESIOLOGY	0.053790	1,406,538	0	0	75,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367	6,702,796	0	0	1,088,313	54.00
56.00	05600	RADIOISOTOPE	0.157159	1,113,153	0	0	174,942	56.00
57.00	05700	CT SCAN	0.028574	9,883,706	0	0	282,417	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158	3,895,637	0	0	343,432	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912	1,269,736	0	0	177,651	59.00
60.00	06000	LABORATORY	0.113389	5,420,497	0	0	614,625	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964	284,950	0	0	68,093	63.00
65.00	06500	RESPIRATORY THERAPY	0.239277	238,754	0	0	57,128	65.00
66.00	06600	PHYSICAL THERAPY	0.324392	12,882	0	0	4,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751	4,738	0	0	1,415	67.00
68.00	06800	SPEECH PATHOLOGY	0.315494	438	0	0	138	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177	6,061,237	0	0	570,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135	1,478,063	0	0	448,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123	5,319,592	0	0	2,043,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302	15,807,698	0	26,892	4,114,775	73.00
74.00	07400	RENAL DIALYSIS	0.376728	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0.478349	624,531	0	0	298,744	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854	2,325,830	0	0	520,646	76.01
76.02	03550	OP PSYCH	0.351739	2,056,353	0	0	723,300	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132	1,500,504	0	0	208,768	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.129725	6,653,495	0	0	863,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455	403,855	0	0	453,309	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.258786		0			95.00
200.00		Subtotal (see instructions)		81,199,032	0	26,892	15,859,316	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		81,199,032	0	26,892	15,859,316	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 2:49 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
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,000		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	7,000		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	7,000		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	996,772	29,950,252	0.033281	0	0	50.00
51.00	05100	RECOVERY ROOM	111,736	5,307,349	0.021053	0	0	51.00
53.00	05300	ANESTHESIOLOGY	83,319	9,783,272	0.008516	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,839	33,069,924	0.025124	42,458	1,067	54.00
56.00	05600	RADIOISOTOPE	45,615	3,903,709	0.011685	0	0	56.00
57.00	05700	CT SCAN	241,917	40,940,539	0.005909	91,041	538	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,368	14,047,245	0.010633	2,328	25	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,965	10,364,878	0.011574	0	0	59.00
60.00	06000	LABORATORY	588,133	48,058,064	0.012238	398,032	4,871	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69,508	5,806,927	0.011970	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	138,550	7,300,208	0.018979	71,453	1,356	65.00
66.00	06600	PHYSICAL THERAPY	218,417	7,264,897	0.030065	10,804	325	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,474	1,813,843	0.028930	1,458	42	67.00
68.00	06800	SPEECH PATHOLOGY	21,457	920,215	0.023317	2,469	58	68.00
69.00	06900	ELECTROCARDIOLOGY	256,895	22,634,401	0.011350	61,604	699	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,511	9,860,350	0.017394	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	526,134	28,465,644	0.018483	449	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	830,720	56,924,624	0.014593	359,482	5,246	73.00
74.00	07400	RENAL DIALYSIS	23,214	1,176,658	0.019729	0	0	74.00
76.00	03020	ONCOLOGY	121,622	3,501,534	0.034734	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	285,293	9,527,812	0.029943	0	0	76.01
76.02	03550	OP PSYCH	135,124	2,572,030	0.052536	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	18,985	3,152,198	0.006023	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	666,133	53,296,558	0.012499	193,870	2,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,515,785	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,703,701	411,158,916		1,235,448	16,658	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,950,252	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	5,307,349	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	9,783,272	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,069,924	0.000000	0.000000	42,458	54.00
56.00	05600	RADIOISOTOPE	0	3,903,709	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	40,940,539	0.000000	0.000000	91,041	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,047,245	0.000000	0.000000	2,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,364,878	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	48,058,064	0.000000	0.000000	398,032	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	5,806,927	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,300,208	0.000000	0.000000	71,453	65.00
66.00	06600	PHYSICAL THERAPY	0	7,264,897	0.000000	0.000000	10,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,813,843	0.000000	0.000000	1,458	67.00
68.00	06800	SPEECH PATHOLOGY	0	920,215	0.000000	0.000000	2,469	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,634,401	0.000000	0.000000	61,604	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,860,350	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	28,465,644	0.000000	0.000000	449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,924,624	0.000000	0.000000	359,482	73.00
74.00	07400	RENAL DIALYSIS	0	1,176,658	0.000000	0.000000	0	74.00
76.00	03020	ONCOLOGY	0	3,501,534	0.000000	0.000000	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	9,527,812	0.000000	0.000000	0	76.01
76.02	03550	OP PSYCH	0	2,572,030	0.000000	0.000000	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,152,198	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	53,296,558	0.000000	0.000000	193,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,515,785	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	411,158,916			1,235,448	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002
Component CCN: 14-S002
Period: From 01/01/2016 To 12/31/2016
Worksheet D Part IV
Date/Time Prepared: 5/24/2017 2:49 pm
Title XVIII
Subprovider - IPF
PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002
Component CCN: 14-5566
Period: From 01/01/2016 To 12/31/2016
Worksheet D Part IV
Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Component CCN: 14-5566 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Skilled Nursing Facility | 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	29,950,252	0.000000	0.000000	1,140	50.00
51.00	05100	RECOVERY ROOM	0	5,307,349	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	9,783,272	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,069,924	0.000000	0.000000	47,812	54.00
56.00	05600	RADIOISOTOPE	0	3,903,709	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	40,940,539	0.000000	0.000000	4,662	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,047,245	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,364,878	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	48,058,064	0.000000	0.000000	479,605	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	5,806,927	0.000000	0.000000	20,306	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,300,208	0.000000	0.000000	250,307	65.00
66.00	06600	PHYSICAL THERAPY	0	7,264,897	0.000000	0.000000	647,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,813,843	0.000000	0.000000	522,754	67.00
68.00	06800	SPEECH PATHOLOGY	0	920,215	0.000000	0.000000	33,299	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,634,401	0.000000	0.000000	31,900	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,860,350	0.000000	0.000000	40,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	28,465,644	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,924,624	0.000000	0.000000	808,057	73.00
74.00	07400	RENAL DIALYSIS	0	1,176,658	0.000000	0.000000	117,300	74.00
76.00	03020	ONCOLOGY	0	3,501,534	0.000000	0.000000	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	9,527,812	0.000000	0.000000	4,948	76.01
76.02	03550	OP PSYCH	0	2,572,030	0.000000	0.000000	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,152,198	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	53,296,558	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,515,785	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	411,158,916			3,010,213	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Component CCN: 14-5566 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002 Component CCN: 14-5566	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/24/2017 2:49 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	2,607,886	0	2,607,886	22,923	113.77	30.00
31.00	INTENSIVE CARE UNIT	374,390		374,390	2,682	139.59	31.00
40.00	SUBPROVIDER - IPF	269,520	0	269,520	2,781	96.91	40.00
44.00	SKILLED NURSING FACILITY	246,019		246,019	4,671	52.67	44.00
200.00	Total (lines 30-199)	3,497,815		3,497,815	33,057		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,177	247,677	30.00
31.00	INTENSIVE CARE UNIT	114	15,913	31.00
40.00	SUBPROVIDER - IPF	21	2,035	40.00
44.00	SKILLED NURSING FACILITY	42	2,212	44.00
200.00	Total (lines 30-199)	2,354	267,837	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/24/2017 2:49 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	996,772	29,950,252	0.033281	735,270	24,471	50.00
51.00	05100	RECOVERY ROOM	111,736	5,307,349	0.021053	45,452	957	51.00
53.00	05300	ANESTHESIOLOGY	83,319	9,783,272	0.008516	130,386	1,110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,839	33,069,924	0.025124	146,916	3,691	54.00
56.00	05600	RADIOISOTOPE	45,615	3,903,709	0.011685	10,154	119	56.00
57.00	05700	CT SCAN	241,917	40,940,539	0.005909	377,161	2,229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,368	14,047,245	0.010633	48,153	512	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,965	10,364,878	0.011574	132,126	1,529	59.00
60.00	06000	LABORATORY	588,133	48,058,064	0.012238	1,043,411	12,769	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69,508	5,806,927	0.011970	410,509	4,914	63.00
65.00	06500	RESPIRATORY THERAPY	138,550	7,300,208	0.018979	173,032	3,284	65.00
66.00	06600	PHYSICAL THERAPY	218,417	7,264,897	0.030065	31,982	962	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,474	1,813,843	0.028930	10,499	304	67.00
68.00	06800	SPEECH PATHOLOGY	21,457	920,215	0.023317	815	19	68.00
69.00	06900	ELECTROCARDIOLOGY	256,895	22,634,401	0.011350	172,487	1,958	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,511	9,860,350	0.017394	3,038	53	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	526,134	28,465,644	0.018483	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	830,720	56,924,624	0.014593	835,800	12,197	73.00
74.00	07400	RENAL DIALYSIS	23,214	1,176,658	0.019729	18,830	371	74.00
76.00	03020	ONCOLOGY	121,622	3,501,534	0.034734	1,685	59	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	285,293	9,527,812	0.029943	44,736	1,340	76.01
76.02	03550	OP PSYCH	135,124	2,572,030	0.052536	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	18,985	3,152,198	0.006023	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	666,133	53,296,558	0.012499	443,011	5,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	194,201	1,515,785	0.128119	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,897,902	411,158,916		4,815,453	78,385	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/24/2017 2:49 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,923	0.00	2,177	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,682	0.00	114	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,781	0.00	21	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	4,671	0.00	42	0	0	44.00
200.00		Total (lines 30-199)	33,057		2,354	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0			44.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 2:49 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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 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	29,950,252	0.000000	0.000000	735,270	50.00
51.00	05100	RECOVERY ROOM	0	5,307,349	0.000000	0.000000	45,452	51.00
53.00	05300	ANESTHESIOLOGY	0	9,783,272	0.000000	0.000000	130,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,069,924	0.000000	0.000000	146,916	54.00
56.00	05600	RADIOISOTOPE	0	3,903,709	0.000000	0.000000	10,154	56.00
57.00	05700	CT SCAN	0	40,940,539	0.000000	0.000000	377,161	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,047,245	0.000000	0.000000	48,153	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,364,878	0.000000	0.000000	132,126	59.00
60.00	06000	LABORATORY	0	48,058,064	0.000000	0.000000	1,043,411	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	5,806,927	0.000000	0.000000	410,509	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,300,208	0.000000	0.000000	173,032	65.00
66.00	06600	PHYSICAL THERAPY	0	7,264,897	0.000000	0.000000	31,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,813,843	0.000000	0.000000	10,499	67.00
68.00	06800	SPEECH PATHOLOGY	0	920,215	0.000000	0.000000	815	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,634,401	0.000000	0.000000	172,487	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,860,350	0.000000	0.000000	3,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	28,465,644	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,924,624	0.000000	0.000000	835,800	73.00
74.00	07400	RENAL DIALYSIS	0	1,176,658	0.000000	0.000000	18,830	74.00
76.00	03020	ONCOLOGY	0	3,501,534	0.000000	0.000000	1,685	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	9,527,812	0.000000	0.000000	44,736	76.01
76.02	03550	OP PSYCH	0	2,572,030	0.000000	0.000000	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,152,198	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	53,296,558	0.000000	0.000000	443,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,515,785	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	411,158,916			4,815,453	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 2:49 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/24/2017 2:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 2:49 pm

Title XIX | 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	0.326046	0	2,239,789	0	0	50.00
51.00	05100	RECOVERY ROOM	0.217435	0	323,823	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.053790	0	488,171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367	0	1,858,315	0	0	54.00
56.00	05600	RADIOISOTOPE	0.157159	0	116,704	0	0	56.00
57.00	05700	CT SCAN	0.028574	0	1,756,805	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158	0	565,430	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912	0	121,088	0	0	59.00
60.00	06000	LABORATORY	0.113389	0	1,667,293	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964	0	207,873	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.239277	0	42,180	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324392	0	167,037	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751	0	42,851	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.315494	0	79,207	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177	0	698,289	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135	0	696	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302	0	2,086,841	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.376728	0	0	0	0	74.00
76.00	03020	ONCOLOGY	0.478349	0	150,895	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854	0	227,573	0	0	76.01
76.02	03550	OP PSYCH	0.351739	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.129725	0	4,002,017	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455	0	256,332	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.258786	0	1,089,192			95.00
200.00		Subtotal (see instructions)		0	18,188,401	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	18,188,401	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 2:49 pm

Title XIX | 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	730,274	0		50.00
51.00	05100	RECOVERY ROOM	70,410	0		51.00
53.00	05300	ANESTHESIOLOGY	26,259	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,729	0		54.00
56.00	05600	RADIOISOTOPE	18,341	0		56.00
57.00	05700	CT SCAN	50,199	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	49,847	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	16,942	0		59.00
60.00	06000	LABORATORY	189,053	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	49,674	0		63.00
65.00	06500	RESPIRATORY THERAPY	10,093	0		65.00
66.00	06600	PHYSICAL THERAPY	54,185	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,802	0		67.00
68.00	06800	SPEECH PATHOLOGY	24,989	0		68.00
69.00	06900	ELECTROCARDIOLOGY	65,763	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	211	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	543,209	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY	72,180	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	50,943	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	519,162	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287,721	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	281,868			95.00
200.00		Subtotal (see instructions)	3,425,854	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,425,854	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 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)	22,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,923	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)	21,216	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)	9,532	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)	22,847,730	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)	22,847,730	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)	22,847,730	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)	996.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,500,735	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)	9,500,735	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 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	4,504,059	2,682	1,679.37	1,228	2,062,266	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)	12,356,744	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,919,745	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,255,873	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	959,584	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,215,457	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,704,288	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,707	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	996.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,701,401	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 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	2,607,886	22,847,730	0.114142	1,701,401	194,201	90.00
91.00	Nursing School cost	0	22,847,730	0.000000	1,701,401	0	91.00
92.00	Allied health cost	0	22,847,730	0.000000	1,701,401	0	92.00
93.00	All other Medical Education	0	22,847,730	0.000000	1,701,401	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,781	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,781	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,781	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,500	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,914,188	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,914,188	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,914,188	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)	1,047.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,619,725	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,619,725	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	201,347	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,821,072	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)	242,275	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	16,658	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	258,933	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,562,139	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	269,520	2,914,188	0.092485	0	0	90.00
91.00	Nursing School cost	0	2,914,188	0.000000	0	0	91.00
92.00	Allied health cost	0	2,914,188	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,914,188	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0002 Component CCN: 14-5566	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,671	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,671	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,773	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)	3,460,155	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)	3,460,155	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)	3,460,155	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002 | Component CCN: 14-5566 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,460,155	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	740.77	71.00
72.00	Program routine service cost (line 9 x line 71)	2,054,155	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,054,155	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,054,155	83.00
84.00	Program inpatient ancillary services (see instructions)	775,078	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,829,233	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0002 Component CCN: 14-5566	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 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)	22,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,923	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)	21,216	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,177	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)	22,847,730	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)	22,847,730	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)	22,847,730	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)	996.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,169,859	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,169,859	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 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	4,504,059	2,682	1,679.37	114	191,448	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)	897,275	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,258,582	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)	263,590	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	78,385	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	341,975	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,916,607	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,707	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	996.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,701,401	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 2:49 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	2,607,886	22,847,730	0.114142	1,701,401	194,201	90.00
91.00	Nursing School cost	0	22,847,730	0.000000	1,701,401	0	91.00
92.00	Allied health cost	0	22,847,730	0.000000	1,701,401	0	92.00
93.00	All other Medical Education	0	22,847,730	0.000000	1,701,401	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 2:49 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		16,714,510		30.00
31.00	03100	INTENSIVE CARE UNIT		4,386,452		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326046	4,494,414	1,465,386	50.00
51.00	05100	RECOVERY ROOM	0.217435	479,812	104,328	51.00
53.00	05300	ANESTHESIOLOGY	0.053790	1,499,701	80,669	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367	1,968,845	319,675	54.00
56.00	05600	RADIOISOTOPE	0.157159	336,486	52,882	56.00
57.00	05700	CT SCAN	0.028574	4,611,424	131,767	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158	763,646	67,322	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912	1,140,064	159,509	59.00
60.00	06000	LABORATORY	0.113389	9,480,647	1,075,001	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964	765,305	182,880	63.00
65.00	06500	RESPIRATORY THERAPY	0.239277	3,244,628	776,365	65.00
66.00	06600	PHYSICAL THERAPY	0.324392	683,589	221,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751	192,445	57,493	67.00
68.00	06800	SPEECH PATHOLOGY	0.315494	122,512	38,652	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177	4,711,976	443,760	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135	1,979,467	600,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123	7,309,653	2,807,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302	10,729,935	2,793,024	73.00
74.00	07400	RENAL DIALYSIS	0.376728	661,998	249,393	74.00
76.00	03020	ONCOLOGY	0.478349	8,874	4,245	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854	470,741	105,377	76.01
76.02	03550	OP PSYCH	0.351739	2,542	894	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.129725	3,624,022	470,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455	132,204	148,393	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		59,414,930	12,356,744	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)		59,414,930		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,685,655		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326046	0	0	50.00
51.00	05100	RECOVERY ROOM	0.217435	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.053790	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367	42,458	6,894	54.00
56.00	05600	RADIOISOTOPE	0.157159	0	0	56.00
57.00	05700	CT SCAN	0.028574	91,041	2,601	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158	2,328	205	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912	0	0	59.00
60.00	06000	LABORATORY	0.113389	398,032	45,132	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.239277	71,453	17,097	65.00
66.00	06600	PHYSICAL THERAPY	0.324392	10,804	3,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751	1,458	436	67.00
68.00	06800	SPEECH PATHOLOGY	0.315494	2,469	779	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177	61,604	5,802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123	449	172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302	359,482	93,574	73.00
74.00	07400	RENAL DIALYSIS	0.376728	0	0	74.00
76.00	03020	ONCOLOGY	0.478349	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854	0	0	76.01
76.02	03550	OP PSYCH	0.351739	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.129725	193,870	25,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,235,448	201,347	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,235,448		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0002 | Component CCN: 14-5566 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326046	1,140	372	50.00
51.00	05100	RECOVERY ROOM	0.217435	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.053790	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367	47,812	7,763	54.00
56.00	05600	RADIOISOTOPE	0.157159	0	0	56.00
57.00	05700	CT SCAN	0.028574	4,662	133	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912	0	0	59.00
60.00	06000	LABORATORY	0.113389	479,605	54,382	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964	20,306	4,852	63.00
65.00	06500	RESPIRATORY THERAPY	0.239277	250,307	59,893	65.00
66.00	06600	PHYSICAL THERAPY	0.324392	647,764	210,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751	522,754	156,173	67.00
68.00	06800	SPEECH PATHOLOGY	0.315494	33,299	10,506	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177	31,900	3,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135	40,359	12,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302	808,057	210,339	73.00
74.00	07400	RENAL DIALYSIS	0.376728	117,300	44,190	74.00
76.00	03020	ONCOLOGY	0.478349	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854	4,948	1,108	76.01
76.02	03550	OP PSYCH	0.351739	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.129725	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,010,213	775,078	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)		3,010,213		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 2:49 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		2,582,118		30.00
31.00	03100	INTENSIVE CARE UNIT		393,340		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326046	735,270	239,732	50.00
51.00	05100	RECOVERY ROOM	0.217435	45,452	9,883	51.00
53.00	05300	ANESTHESIOLOGY	0.053790	130,386	7,013	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162367	146,916	23,854	54.00
56.00	05600	RADIOISOTOPE	0.157159	10,154	1,596	56.00
57.00	05700	CT SCAN	0.028574	377,161	10,777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088158	48,153	4,245	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.139912	132,126	18,486	59.00
60.00	06000	LABORATORY	0.113389	1,043,411	118,311	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238964	410,509	98,097	63.00
65.00	06500	RESPIRATORY THERAPY	0.239277	173,032	41,403	65.00
66.00	06600	PHYSICAL THERAPY	0.324392	31,982	10,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298751	10,499	3,137	67.00
68.00	06800	SPEECH PATHOLOGY	0.315494	815	257	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094177	172,487	16,244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303135	3,038	921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384123	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260302	835,800	217,560	73.00
74.00	07400	RENAL DIALYSIS	0.376728	18,830	7,094	74.00
76.00	03020	ONCOLOGY	0.478349	1,685	806	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.223854	44,736	10,014	76.01
76.02	03550	OP PSYCH	0.351739	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.139132	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.129725	443,011	57,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.122455	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,815,453	897,275	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)		4,815,453		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 2:49 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)	15,152,254	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,012,190	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)	189,809	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)	127.34	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)	3.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.86	31.00
32.00	Sum of lines 30 and 31	24.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.68	33.00
34.00	Disproportionate share adjustment (see instructions)	487,980	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 2:49 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)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	787,614	741,802	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	589,635	186,975	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	776,610		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)	21,618,843		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)	21,618,843	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,722,460	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)	23,341,303	59.00
60.00	Primary payer payments	17,792	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	23,323,511	61.00
62.00	Deductibles billed to program beneficiaries	2,532,833	62.00
63.00	Coinsurance billed to program beneficiaries	59,892	63.00
64.00	Allowable bad debts (see instructions)	647,525	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	420,891	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	462,781	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	21,151,677	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)	157,513	70.93
70.94	HRR adjustment amount (see instructions)	-176,397	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/24/2017 2:49 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)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,132,793	71.00
71.01	Sequestration adjustment (see instructions)		422,656	71.01
72.00	Interim payments		20,671,035	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)		39,102	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		375,563	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 DSH PAYMENT PERCENTAGE | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet DSH | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.94	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.86	0.00			20.86	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	24.80	0.00			20.86	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	127.34	0.00			127.34	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	9.68	0.00			6.42	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	3.94	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,757	0			1,757	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	480	0			480	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	54	0			54	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,695	0			2,695	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4,986	0			4,986	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	23,898	0			23,898	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	23,898	0			23,898	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.86	0.00			20.86	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet DSH | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	9.67		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		9.67		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		9.67		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet DSH Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Hospital	PPS

		Revised Percentage
		6.00
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE	
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	6.42
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00
30.00	Line 28 or 29 as applicable	6.42
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	6.42

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part B Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,000	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,859,316	2.00
3.00	PPS payments	14,587,510	3.00
4.00	Outlier payment (see instructions)	58,985	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)	7,000	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	26,892	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)	26,892	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)	26,892	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19,892	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)	7,000	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)	14,646,495	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,855,713	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)	11,797,782	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)	11,797,782	30.00
31.00	Primary payer payments	2,914	31.00
32.00	Subtotal (line 30 minus line 31)	11,794,868	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)	640,902	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	416,586	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	464,462	36.00
37.00	Subtotal (see instructions)	12,211,454	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)	12,211,454	40.00
40.01	Sequestration adjustment (see instructions)	244,229	40.01
41.00	Interim payments	11,995,015	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-27,790	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2017 2:49 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		20,572,435		11,995,015	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	06/27/2016	98,600		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)		98,600		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)		20,671,035		11,995,015	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		39,102		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		27,790	6.02
7.00	Total Medicare program liability (see instructions)		20,710,137		11,967,225	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002 | Component CCN: 14-S002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,077,368		0	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)		2,077,368		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		23,169		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,100,537		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002 | Component CCN: 14-5566 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2017 2:49 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		896,129		0	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)		896,129		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		700		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		896,829		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/24/2017 2:49 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	6,838	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	10,760	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,418	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	23,898	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	485,104,119	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	9,916,685	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)	475,141	8.00
9.00	Sequestration adjustment amount (see instructions)	9,503	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	465,638	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	464,340	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)	1,298	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,155,877	1.00
2.00	Net IPF PPS Outlier Payments	130,015	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.598361	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,285,892	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,285,892	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,285,892	18.00
19.00	Deductibles	136,500	19.00
20.00	Subtotal (line 18 minus line 19)	2,149,392	20.00
21.00	Coinsurance	29,624	21.00
22.00	Subtotal (line 20 minus line 21)	2,119,768	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	36,365	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	23,637	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,482	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,143,405	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,143,405	31.00
31.01	Sequestration adjustment (see instructions)	42,868	31.01
32.00	Interim payments	2,077,368	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	23,169	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	130,015	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002 Component CCN: 14-5566	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	973,343	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	973,343	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	58,926	7.00
8.00	Allowable bad debts (see instructions)	1,100	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	715	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	915,132	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	915,132	15.00
15.01	Sequestration adjustment (see instructions)	18,303	15.01
16.00	Interim payments	896,129	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	700	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/24/2017 2:49 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	504,379	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,786,957	0	0	0	4.00
5.00	Other receivable	923,911	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,942,670	0	0	0	7.00
8.00	Prepaid expenses	56,054	0	0	0	8.00
9.00	Other current assets	2,423,059	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)	26,637,030	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	177,168	0	0	0	12.00
13.00	Land improvements	6,116,327	0	0	0	13.00
14.00	Accumulated depreciation	-5,028,552	0	0	0	14.00
15.00	Buildings	96,658,891	0	0	0	15.00
16.00	Accumulated depreciation	-51,251,361	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	35,602,508	0	0	0	19.00
20.00	Accumulated depreciation	-30,156,567	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	54,224,423	0	0	0	23.00
24.00	Accumulated depreciation	-44,753,273	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	5,298,938	0	0	0	27.00
28.00	Accumulated depreciation	-2,606,049	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)	64,282,453	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	90,919,483	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	896,523	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,519,495	0	0	0	38.00
39.00	Payroll taxes payable	1,314,011	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,155,424	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,885,453	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	282,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	282,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,167,453	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	80,752,030				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)	80,752,030	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	90,919,483	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/24/2017 2:49 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		75,176,586		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		184,893				2.00
3.00	Total (sum of line 1 and line 2)		75,361,479		0		3.00
4.00	TRANSFER FROM BJC	5,435,658		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)		5,435,658		0		10.00
11.00	Subtotal (line 3 plus line 10)		80,797,137		0		11.00
12.00	CHANGE IN RESTRICTED ASSETS	45,107		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)		45,107		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		80,752,030		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	TRANSFER FROM BJC		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	CHANGE IN RESTRICTED ASSETS		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2017 2:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	37,307,643		37,307,643	1.00
2.00	SUBPROVIDER - IPF	5,307,349		5,307,349	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	3,554,631		3,554,631	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)	46,169,623		46,169,623	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,200,809		9,200,809	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)	9,200,809		9,200,809	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,370,432		55,370,432	17.00
18.00	Ancillary services	128,415,911	284,179,223	412,595,134	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	3,825	18,658,069	18,661,894	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	183,790,168	302,837,292	486,627,460	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		135,268,398		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	NON OPERATING EXPENSES	1,337,301			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)		1,337,301		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		133,931,097		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0002 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/24/2017 2:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	486,627,460	1.00
2.00	Less contractual allowances and discounts on patients' accounts	348,979,904	2.00
3.00	Net patient revenues (line 1 minus line 2)	137,647,556	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	133,931,097	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,716,459	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	87,672	6.00
7.00	Income from investments	119,789	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	957,636	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFULE USE MEDICARE	427,409	24.00
24.01	BJC OTHER OPERATING REVENUE	106,424	24.01
24.02	OTHER OPERATING REVENUE	2,973,816	24.02
25.00	Total other income (sum of lines 6-24)	4,672,746	25.00
26.00	Total (line 5 plus line 25)	8,389,205	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS	8,312,254	27.00
27.01	PHYSICIAN OFFICE BUILDINGS	132,837	27.01
27.02	EUNICE SMITH NET INCOME	-239,984	27.02
27.03	TWIN RIVERS NETINCOME	-795	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	8,204,312	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	184,893	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0002	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/24/2017 2:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,608,849	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	30,755	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)	65.30	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)	3.94	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	20.86	8.00
9.00	Sum of lines 7 and 8	24.80	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.15	10.00
11.00	Disproportionate share adjustment (see instructions)	82,856	11.00
12.00	Total prospective capital payments (see instructions)	1,722,460	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