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: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 4:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2017 Time: 4:37 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 FHN MEMORIAL HOSPITAL (14-0160) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	11,697	-88,990	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	11,697	-88,990	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 7:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1405 WEST STEPHENSON STREET	PO Box:			1.00
2.00	City: FREEPORT	State: IL	Zip Code: 64032	County: STEPHENSON	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	FHN MEMORIAL HOSPITAL	140160	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									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	FHN MEMORIAL - HOSPICE	141560	99914		08/12/1993				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.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,316	284	1	8	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 7:46 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.	2		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.	2		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.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2016	12/31/2016	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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)				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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 7:46 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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 7:46 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,170,144	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	Y	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.	N		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: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 7:46 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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.	N	N	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 7:46 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	12/31/2016	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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2017 7:46 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.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/22/2017	Y	05/22/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2017 7:46 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					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		LINHART		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404		DAN.LINHART@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 7:46 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 7:46 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	92	33,672	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)		92	33,672	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		100	36,600	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		100				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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2017 7:46 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)	5,463	2,086	11,881			1.00
2.00	HMO and other (see instructions)	2,987	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,463	2,086	11,881			7.00
8.00	INTENSIVE CARE UNIT	589	63	1,258			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		460	705			13.00
14.00	Total (see instructions)	6,052	2,609	13,844	0.00	530.22	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	17.22	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	547.44	27.00
28.00	Observation Bed Days		0	3,915			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	106			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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2017 7:46 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	1,532	807	3,827	1.00
2.00	HMO and other (see instructions)			726	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,532	807	3,827	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/23/2017 7:46 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	31,695,433	0	31,695,433	1,138,682.90	27.84	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,663,225	0	1,663,225	15,333.00	108.47	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		945,532	28,127	973,659	36,638.40	26.57	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		941,389	0	941,389	15,134.00	62.20	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		21,039	0	21,039	526.00	40.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		4,558,909	0	4,558,909	141,075.00	32.32	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	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)		9,188,855	0	9,188,855			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		309,575	0	309,575			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		210,019	0	210,019			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		0	0	0			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/23/2017 7:46 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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,419,520	-22,410	2,397,110	107,382.40	22.32	27.00
28.00	Administrative & General under contract (see inst.)		132,744	0	132,744	1,085.80	122.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	283,915	0	283,915	18,310.70	15.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,358,927	0	1,358,927	87,905.26	15.46	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,592,888	0	1,592,888	74,174.24	21.47	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	660,861	0	660,861	17,027.60	38.81	38.00
39.00	Central Services and Supply	14.00	85,360	0	85,360	6,274.40	13.60	39.00
40.00	Pharmacy	15.00	1,128,982	0	1,128,982	37,800.70	29.87	40.00
41.00	Medical Records & Medical Records Library	16.00	1,246,273	0	1,246,273	49,664.20	25.09	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/23/2017 7:46 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)		33,116,767	0	33,116,767	1,286,515.20	25.74	1.00
2.00	Excluded area salaries (see instructions)		945,532	28,127	973,659	36,638.40	26.57	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,171,235	-28,127	32,143,108	1,249,876.80	25.72	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,521,337	0	5,521,337	156,735.00	35.23	4.00
5.00	Subtotal wage-related costs (see inst.)		9,188,855	0	9,188,855	0.00	28.59	5.00
6.00	Total (sum of lines 3 thru 5)		46,881,427	-28,127	46,853,300	1,406,611.80	33.31	6.00
7.00	Total overhead cost (see instructions)		8,909,470	-22,410	8,887,060	399,625.30	22.24	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/23/2017 7:46 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,086,975	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5,682,036	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	173,253	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	50,124	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)	106,790	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	185,177	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,405,292	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	18,802	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,708,449	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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/23/2017 7:46 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	941,389	9,708,449	1.00
2.00	Hospital	941,389	9,708,449	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 14-0160 | Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	11,961	184	512	12,657	11.00
12.00	Hospice Inpatient Respite Care	10	0	0	10	12.00
13.00	Hospice General Inpatient Care	3	0	0	3	13.00
14.00	Total Hospice Days	11,974	184	512	12,670	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/23/2017 7:46 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)	0.233346	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,812,988	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	5,592,584	5.00
6.00	Medicaid charges	78,452,621	6.00
7.00	Medicaid cost (line 1 times line 6)	18,306,605	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)	5,901,033	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	115,295	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,901,033	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)	2,244,767	525,579	2,770,346	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	523,807	122,642	646,449	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	523,807	122,642	646,449	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,930,245	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	572,460	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,357,785	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,483,564	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,130,013	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,031,046	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,505,894	1,505,894	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,732,522	2,732,522	-1,505,894	1,226,628	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,699,188	9,699,188	0	9,699,188	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,419,520	19,191,784	21,611,304	-26,637	21,584,667	5.00
7.00	00700	OPERATION OF PLANT	283,915	3,020,877	3,304,792	0	3,304,792	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	453,334	453,334	0	453,334	8.00
9.00	00900	HOUSEKEEPING	0	1,693,685	1,693,685	0	1,693,685	9.00
10.00	01000	DIETARY	0	2,679,082	2,679,082	-1,288,035	1,391,047	10.00
11.00	01100	CAFETERIA	0	0	0	1,288,035	1,288,035	11.00
13.00	01300	NURSING ADMINISTRATION	660,861	219,859	880,720	0	880,720	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	85,360	389,910	475,270	0	475,270	14.00
15.00	01500	PHARMACY	1,128,982	4,193,754	5,322,736	-3,245,911	2,076,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,246,273	492,897	1,739,170	0	1,739,170	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,888,529	2,200,042	11,088,571	-6,227	11,082,344	30.00
31.00	03100	INTENSIVE CARE UNIT	1,285,758	494,498	1,780,256	0	1,780,256	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,911,716	4,733,203	6,644,919	0	6,644,919	50.00
50.01	05001	GI LAB	1,079,659	933,948	2,013,607	0	2,013,607	50.01
50.02	05002	AMBULATORY CARE UNIT	928,574	407,434	1,336,008	0	1,336,008	50.02
51.00	05100	RECOVERY ROOM	519,252	17,531	536,783	0	536,783	51.00
53.00	05300	ANESTHESIOLOGY	0	711,157	711,157	0	711,157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,294,606	4,351,414	6,646,020	0	6,646,020	54.00
60.00	06000	LABORATORY	1,342,489	3,350,026	4,692,515	0	4,692,515	60.00
65.00	06500	RESPIRATORY THERAPY	799,322	270,938	1,070,260	0	1,070,260	65.00
66.00	06600	PHYSICAL THERAPY	2,230,488	152,173	2,382,661	0	2,382,661	66.00
69.00	06900	ELECTROCARDIOLOGY	237,182	353,430	590,612	0	590,612	69.00
69.01	06901	CATH LAB	421,877	1,197,307	1,619,184	0	1,619,184	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,245,911	3,245,911	73.00
76.00	03950	DIABETIC EDUCATION	0	100,502	100,502	0	100,502	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	676,986	676,986	0	676,986	90.00
91.00	09100	EMERGENCY	2,985,538	6,505,032	9,490,570	0	9,490,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	945,532	946,545	1,892,077	0	1,892,077	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,695,433	72,169,058	103,864,491	-32,864	103,831,627	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,548	5,548	0	5,548	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	26,637	26,637	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	6,227	6,227	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	31,695,433	72,174,606	103,870,039	0	103,870,039	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,505,894		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,226,628		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,699,188		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,354,477	20,230,190		5.00
7.00	00700	OPERATION OF PLANT	0	3,304,792		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	453,334		8.00
9.00	00900	HOUSEKEEPING	0	1,693,685		9.00
10.00	01000	DIETARY	-298,497	1,092,550		10.00
11.00	01100	CAFETERIA	-131	1,287,904		11.00
13.00	01300	NURSING ADMINISTRATION	-169,694	711,026		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	475,270		14.00
15.00	01500	PHARMACY	-8,614	2,068,211		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,425	1,736,745		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,947,600	8,134,744		30.00
31.00	03100	INTENSIVE CARE UNIT	-356,677	1,423,579		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,644,919		50.00
50.01	05001	GI LAB	0	2,013,607		50.01
50.02	05002	AMBULATORY CARE UNIT	0	1,336,008		50.02
51.00	05100	RECOVERY ROOM	0	536,783		51.00
53.00	05300	ANESTHESIOLOGY	0	711,157		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,353,108	4,292,912		54.00
60.00	06000	LABORATORY	-566,239	4,126,276		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,070,260		65.00
66.00	06600	PHYSICAL THERAPY	-6,841	2,375,820		66.00
69.00	06900	ELECTROCARDIOLOGY	-96,337	494,275		69.00
69.01	06901	CATH LAB	0	1,619,184		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,245,911		73.00
76.00	03950	DIABETIC EDUCATION	-2,520	97,982		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	676,986		90.00
91.00	09100	EMERGENCY	-5,531,825	3,958,745		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-24,833	1,867,244		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-13,719,818	90,111,809		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,548		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	JANE ADDAMS BLDG	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	0	26,637		192.03
192.04	19204	SMART STEPS	0	0		192.04
192.05	19205	RESPITE CARE	0	6,227		192.05
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-13,719,818	90,150,221		200.00

RECLASSIFICATIONS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 7:46 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,245,911		1.00
	TOTALS		0	3,245,911		
	C - SHARED DIETARY EXPENSES					
1.00	CAFETERIA	11.00	0	1,288,035		1.00
	TOTALS		0	1,288,035		
	D - RESPITE CARE (B)					
1.00	RESPITE CARE	192.05	5,717	510		1.00
	TOTALS		5,717	510		
	E - NON PATIENT VOLUNTEER ADMIN					
1.00	NA VOLUNTEER SERVICES	192.03	22,410	4,227		1.00
	TOTALS		22,410	4,227		
	G - BUILDING DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,505,894		1.00
	TOTALS		0	1,505,894		
500.00	Grand Total: Increases		28,127	6,044,577		500.00

RECLASSIFICATIONS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 7:46 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	3,245,911	0		1.00
	TOTALS		0	3,245,911			
	C - SHARED DIETARY EXPENSES						
1.00	DIETARY	10.00	0	1,288,035	0		1.00
	TOTALS		0	1,288,035			
	D - RESPITE CARE (B)						
1.00	ADULTS & PEDIATRICS	30.00	5,717	510	0		1.00
	TOTALS		5,717	510			
	E - NON PATIENT VOLUNTEER ADMIN						
1.00	ADMINISTRATIVE & GENERAL	5.00	22,410	4,227	0		1.00
	TOTALS		22,410	4,227			
	G - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,505,894	9		1.00
	TOTALS		0	1,505,894			
500.00	Grand Total: Decreases		28,127	6,044,577			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 5/23/2017 7:46 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	944,945	0	0	0	0	1.00
2.00	Land Improvements	1,787,069	0	0	0	15,544	2.00
3.00	Buildings and Fixtures	49,693,080	5,996,710	0	5,996,710	3,955,509	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,386,502	0	0	0	20,741	5.00
6.00	Movable Equipment	22,313,450	1,861,057	0	1,861,057	2,025,144	6.00
7.00	HIT designated Assets	3,246,690	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,371,736	7,857,767	0	7,857,767	6,016,938	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	79,371,736	7,857,767	0	7,857,767	6,016,938	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	944,945	0	1.00
2.00	Land Improvements	1,771,525	0	2.00
3.00	Buildings and Fixtures	51,734,281	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,365,761	0	5.00
6.00	Movable Equipment	22,149,363	0	6.00
7.00	HIT designated Assets	3,246,690	0	7.00
8.00	Subtotal (sum of lines 1-7)	81,212,565	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	81,212,565	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/23/2017 7:46 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,732,522	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,732,522	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,732,522		2.00
3.00	Total (sum of lines 1-2)	0	2,732,522		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2017 7:46 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	59,063,202	0	59,063,202	0.727267	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,149,363	0	22,149,363	0.272733	0	2.00
3.00	Total (sum of lines 1-2)	81,212,565	0	81,212,565	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,505,894	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,226,628	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,732,522	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,505,894	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,226,628	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,732,522	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 7:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,022,150			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	-1,185,040			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 7:46 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRADE, QUANTITY AND TIME DISCOUNTS	B	-13,885	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CAFETERIA--EMPLOYEES AND GUESTS	B	-282,387	DIETARY	10.00	0	33.01
33.02	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-8,614	PHARMACY	15.00	0	33.02
33.03	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-2,425	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	VENDING MACHINES	B	-131	CAFETERIA	11.00	0	33.04
33.05	DIETARY REVENUE	B	-275	DIETARY	10.00	0	33.05
33.06	PHYSICIAN COLLECTIONS EXPENSES	A	-93,604	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DIETARY CONSULTING	B	-150	DIETARY	10.00	0	33.07
33.08	TELEPHONE CAPITAL COSTS	A	-8,810	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ASSOC LOBBYING FEES	A	-40,844	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MEALS ON WHEELS	B	-15,685	DIETARY	10.00	0	33.10
33.11	HBP HOSPICE	A	-24,833	HOSPICE	116.00	0	33.11
33.12	OTHER REVENUE MISC	B	-2,572	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	LIFELINE EXPENSE	A	-6,898	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.15	LIFELINE DEPRE	B	-2,104	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OB MISC INCOME	B	-20	ADULTS & PEDIATRICS	30.00	0	33.16
33.19	NONPATIENT DIABETIC REVENUE	B	-2,520	DIABETIC EDUCATION	76.00	0	33.19
33.20	RADIOLOGY MED RECORD REVENUE	B	-30	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.22	PT, OT, SPORTS MED MISC INCOME	B	-6,841	PHYSICAL THERAPY	66.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,719,818				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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2017 7:46 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	CORPORATE ALLOCATION	9,756,170	10,941,210	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,756,170	10,941,210	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:					
6.00	A	FREEPORT MEMORI	100.00	FREEPORT HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/23/2017 7:46 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,185,040	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,185,040			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	HEALTH CARE PARENT CO		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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2017 7:46 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,284,355	1,284,355	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	356,677	356,677	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	169,694	169,694	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	2,353,078	2,353,078	0	0	0	5.00
6.00	60.00	LABORATORY	566,239	566,239	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	96,337	96,337	0	0	0	7.00
8.00	69.01	CATH LAB	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	5,531,825	5,531,825	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	1,663,225	1,663,225	0	0	0	10.00
11.00	5.00	ADMINISTRATIVE & GENERAL	21,759	720	21,039	159,800	527	11.00
200.00			12,043,189	12,022,150	21,039		527	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	69.01	CATH LAB	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
11.00	5.00	ADMINISTRATIVE & GENERAL	40,488	2,024	0	0	0	11.00
200.00			40,488	2,024	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,284,355		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	356,677		2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	169,694		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,353,078		5.00
6.00	60.00	LABORATORY	0	0	0	566,239		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	96,337		7.00
8.00	69.01	CATH LAB	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	5,531,825		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,663,225		10.00
11.00	5.00	ADMINISTRATIVE & GENERAL	0	40,488	0	720		11.00
200.00			0	40,488	0	12,022,150		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,505,894	1,505,894				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,226,628		1,226,628			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,699,188	9,632	0	9,708,820		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,230,190	326,264	27,252	734,273	21,317,979	5.00
7.00	00700	OPERATION OF PLANT	3,304,792	173,025	8,501	86,968	3,573,286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	453,334	11,593	0	0	464,927	8.00
9.00	00900	HOUSEKEEPING	1,693,685	25,434	1,067	0	1,720,186	9.00
10.00	01000	DIETARY	1,092,550	57,251	8,104	0	1,157,905	10.00
11.00	01100	CAFETERIA	1,287,904	48,861	0	0	1,336,765	11.00
13.00	01300	NURSING ADMINISTRATION	711,026	1,848	28,923	202,432	944,229	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	475,270	4,420	11,693	26,147	517,530	14.00
15.00	01500	PHARMACY	2,068,211	12,019	5,970	345,825	2,432,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,736,745	21,661	1,110	381,753	2,141,269	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,134,744	282,002	193,000	2,720,949	11,330,695	30.00
31.00	03100	INTENSIVE CARE UNIT	1,423,579	21,368	25,162	393,848	1,863,957	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,644,919	107,113	226,982	585,589	7,564,603	50.00
50.01	05001	GI LAB	2,013,607	34,553	68,085	330,717	2,446,962	50.01
50.02	05002	AMBULATORY CARE UNIT	1,336,008	46,428	10,485	284,437	1,677,358	50.02
51.00	05100	RECOVERY ROOM	536,783	8,261	5,736	159,055	709,835	51.00
53.00	05300	ANESTHESIOLOGY	711,157	4,261	82,185	0	797,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,292,912	86,638	124,838	702,875	5,207,263	54.00
60.00	06000	LABORATORY	4,126,276	43,881	165,289	411,226	4,746,672	60.00
65.00	06500	RESPIRATORY THERAPY	1,070,260	42,064	50,443	244,845	1,407,612	65.00
66.00	06600	PHYSICAL THERAPY	2,375,820	56,188	15,956	683,234	3,131,198	66.00
69.00	06900	ELECTROCARDIOLOGY	494,275	3,245	24,613	72,653	594,786	69.00
69.01	06901	CATH LAB	1,619,184	3,080	49,924	129,228	1,801,416	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,245,911	0	0	0	3,245,911	73.00
76.00	03950	DIABETIC EDUCATION	97,982	2,084	0	0	100,066	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	676,986	0	0	0	676,986	90.00
91.00	09100	EMERGENCY	3,958,745	67,842	87,249	914,518	5,028,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,867,244	0	4,061	289,632	2,160,937	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,111,809	1,501,016	1,226,628	9,700,204	90,098,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,548	3,928	0	0	9,476	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	950	0	0	950	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	26,637	0	0	6,865	33,502	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	6,227	0	0	1,751	7,978	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	90,150,221	1,505,894	1,226,628	9,708,820	90,150,221	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,317,979					5.00
7.00	00700	OPERATION OF PLANT	1,106,679	4,679,965				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	143,992	54,419	663,338			8.00
9.00	00900	HOUSEKEEPING	532,757	119,394	0	2,372,337		9.00
10.00	01000	DIETARY	358,614	268,744	0	141,485	1,926,748	10.00
11.00	01100	CAFETERIA	414,008	229,364	0	120,752	0	11.00
13.00	01300	NURSING ADMINISTRATION	292,436	8,676	0	4,568	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160,284	20,750	0	10,924	0	14.00
15.00	01500	PHARMACY	753,220	56,419	0	29,703	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	663,170	101,680	0	53,531	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,509,232	1,323,763	226,169	696,917	1,822,291	30.00
31.00	03100	INTENSIVE CARE UNIT	577,284	100,306	26,099	52,808	104,457	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,342,826	502,807	48,953	264,711	0	50.00
50.01	05001	GI LAB	757,846	162,196	60,829	85,391	0	50.01
50.02	05002	AMBULATORY CARE UNIT	519,493	217,940	25,396	114,738	0	50.02
51.00	05100	RECOVERY ROOM	219,842	38,778	23,353	20,415	0	51.00
53.00	05300	ANESTHESIOLOGY	247,025	20,003	0	10,531	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,612,736	406,695	74,224	214,111	0	54.00
60.00	06000	LABORATORY	1,470,087	205,986	0	108,445	0	60.00
65.00	06500	RESPIRATORY THERAPY	435,950	197,455	740	103,953	0	65.00
66.00	06600	PHYSICAL THERAPY	969,760	263,755	20,869	138,858	0	66.00
69.00	06900	ELECTROCARDIOLOGY	184,211	15,231	0	8,019	0	69.00
69.01	06901	CATH LAB	557,915	14,460	9,803	7,613	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,005,288	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	30,991	9,785	0	5,151	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	209,669	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,557,326	318,463	146,903	167,660	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	669,262	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,301,903	4,657,069	663,338	2,360,284	1,926,748	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,935	18,437	0	9,706	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	294	4,459	0	2,347	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	10,376	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	2,471	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,317,979	4,679,965	663,338	2,372,337	1,926,748	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,100,889					11.00
13.00	01300	NURSING ADMINISTRATION	34,544	1,284,453				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,886	0	722,374			14.00
15.00	01500	PHARMACY	78,397	0	1,985	3,351,749		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	104,219	0	0	0	3,063,869	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	628,842	869,514	154,741	13,857	211,013	30.00
31.00	03100	INTENSIVE CARE UNIT	78,740	115,539	38,294	595	29,176	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,386	0	35,426	541,456	400,848	50.00
50.01	05001	GI LAB	69,969	0	82,143	5,016	183,083	50.01
50.02	05002	AMBULATORY CARE UNIT	63,697	0	51,398	4,439	17,062	50.02
51.00	05100	RECOVERY ROOM	25,479	0	1,867	0	22,061	51.00
53.00	05300	ANESTHESIOLOGY	0	0	26,635	162,778	56,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,600	0	62,997	6,654	656,489	54.00
60.00	06000	LABORATORY	123,426	0	43,336	2,079	376,682	60.00
65.00	06500	RESPIRATORY THERAPY	63,109	0	35,399	14,450	103,718	65.00
66.00	06600	PHYSICAL THERAPY	154,932	0	8,358	1,559	114,303	66.00
69.00	06900	ELECTROCARDIOLOGY	13,082	0	440	0	73,645	69.00
69.01	06901	CATH LAB	24,303	0	761	6,824	126,593	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,440,067	317,317	73.00
76.00	03950	DIABETIC EDUCATION	0	0	66	0	540	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	57,474	22,082	29,718	90.00
91.00	09100	EMERGENCY	206,772	299,400	112,819	8,190	306,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	73,595	0	8,235	121,703	39,592	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,098,978	1,284,453	722,374	3,351,749	3,063,869	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	1,372	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	539	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,100,889	1,284,453	722,374	3,351,749	3,063,869	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	20,787,034	0	20,787,034		30.00
31.00	03100	INTENSIVE CARE UNIT	2,987,255	0	2,987,255		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,849,016	0	11,849,016		50.00
50.01	05001	GI LAB	3,853,435	0	3,853,435		50.01
50.02	05002	AMBULATORY CARE UNIT	2,691,521	0	2,691,521		50.02
51.00	05100	RECOVERY ROOM	1,061,630	0	1,061,630		51.00
53.00	05300	ANESTHESIOLOGY	1,320,599	0	1,320,599		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,436,769	0	8,436,769		54.00
60.00	06000	LABORATORY	7,076,713	0	7,076,713		60.00
65.00	06500	RESPIRATORY THERAPY	2,362,386	0	2,362,386		65.00
66.00	06600	PHYSICAL THERAPY	4,803,592	0	4,803,592		66.00
69.00	06900	ELECTROCARDIOLOGY	889,414	0	889,414		69.00
69.01	06901	CATH LAB	2,549,688	0	2,549,688		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,008,583	0	7,008,583		73.00
76.00	03950	DIABETIC EDUCATION	146,599	0	146,599		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	995,929	0	995,929		90.00
91.00	09100	EMERGENCY	8,151,892	0	8,151,892		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	3,073,324	0	3,073,324		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,045,379	0	90,045,379		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,554	0	40,554		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,050	0	8,050		192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	45,250	0	45,250		192.03
192.04	19204	SMART STEPS	0	0	0		192.04
192.05	19205	RESPITE CARE	10,988	0	10,988		192.05
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	90,150,221	0	90,150,221		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,632	0	9,632	9,632	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	326,264	27,252	353,516	729	5.00
7.00	00700	OPERATION OF PLANT	0	173,025	8,501	181,526	86	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,593	0	11,593	0	8.00
9.00	00900	HOUSEKEEPING	0	25,434	1,067	26,501	0	9.00
10.00	01000	DIETARY	0	57,251	8,104	65,355	0	10.00
11.00	01100	CAFETERIA	0	48,861	0	48,861	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,848	28,923	30,771	201	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,420	11,693	16,113	26	14.00
15.00	01500	PHARMACY	0	12,019	5,970	17,989	343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,661	1,110	22,771	379	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	282,002	193,000	475,002	2,697	30.00
31.00	03100	INTENSIVE CARE UNIT	0	21,368	25,162	46,530	391	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	107,113	226,982	334,095	581	50.00
50.01	05001	GI LAB	0	34,553	68,085	102,638	328	50.01
50.02	05002	AMBULATORY CARE UNIT	0	46,428	10,485	56,913	282	50.02
51.00	05100	RECOVERY ROOM	0	8,261	5,736	13,997	158	51.00
53.00	05300	ANESTHESIOLOGY	0	4,261	82,185	86,446	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,638	124,838	211,476	698	54.00
60.00	06000	LABORATORY	0	43,881	165,289	209,170	408	60.00
65.00	06500	RESPIRATORY THERAPY	0	42,064	50,443	92,507	243	65.00
66.00	06600	PHYSICAL THERAPY	0	56,188	15,956	72,144	678	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,245	24,613	27,858	72	69.00
69.01	06901	CATH LAB	0	3,080	49,924	53,004	128	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	2,084	0	2,084	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	67,842	87,249	155,091	908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	4,061	4,061	287	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,501,016	1,226,628	2,727,644	9,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,928	0	3,928	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	950	0	950	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	7	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	0	2	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,505,894	1,226,628	2,732,522	9,632	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	354,245					5.00
7.00	00700	OPERATION OF PLANT	18,388	200,000				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,393	2,326	16,312			8.00
9.00	00900	HOUSEKEEPING	8,852	5,102	0	40,455		9.00
10.00	01000	DIETARY	5,959	11,485	0	2,413	85,212	10.00
11.00	01100	CAFETERIA	6,879	9,802	0	2,059	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,859	371	0	78	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,663	887	0	186	0	14.00
15.00	01500	PHARMACY	12,515	2,411	0	507	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,019	4,345	0	913	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,342	56,570	5,562	11,882	80,592	30.00
31.00	03100	INTENSIVE CARE UNIT	9,592	4,287	642	901	4,620	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,927	21,488	1,204	4,514	0	50.00
50.01	05001	GI LAB	12,592	6,931	1,496	1,456	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,632	9,314	625	1,957	0	50.02
51.00	05100	RECOVERY ROOM	3,653	1,657	574	348	0	51.00
53.00	05300	ANESTHESIOLOGY	4,104	855	0	180	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,797	17,380	1,825	3,651	0	54.00
60.00	06000	LABORATORY	24,426	8,803	0	1,849	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,244	8,438	18	1,773	0	65.00
66.00	06600	PHYSICAL THERAPY	16,113	11,272	513	2,368	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,061	651	0	137	0	69.00
69.01	06901	CATH LAB	9,270	618	241	130	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,703	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	515	418	0	88	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,484	0	0	0	0	90.00
91.00	09100	EMERGENCY	25,876	13,610	3,612	2,859	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	11,120	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	353,978	199,021	16,312	40,249	85,212	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49	788	0	166	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5	191	0	40	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	172	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	41	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	354,245	200,000	16,312	40,455	85,212	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	67,601					11.00
13.00	01300	NURSING ADMINISTRATION	1,112	37,392				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	415	0	20,290			14.00
15.00	01500	PHARMACY	2,523	0	56	36,344		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,353	0	0	0	42,780	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,234	25,313	4,347	150	2,950	30.00
31.00	03100	INTENSIVE CARE UNIT	2,534	3,363	1,076	6	408	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,742	0	995	5,871	5,604	50.00
50.01	05001	GI LAB	2,251	0	2,307	54	2,559	50.01
50.02	05002	AMBULATORY CARE UNIT	2,050	0	1,444	48	239	50.02
51.00	05100	RECOVERY ROOM	820	0	52	0	308	51.00
53.00	05300	ANESTHESIOLOGY	0	0	748	1,765	783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,294	0	1,770	72	9,125	54.00
60.00	06000	LABORATORY	3,972	0	1,217	23	5,266	60.00
65.00	06500	RESPIRATORY THERAPY	2,031	0	994	157	1,450	65.00
66.00	06600	PHYSICAL THERAPY	4,985	0	235	17	1,598	66.00
69.00	06900	ELECTROCARDIOLOGY	421	0	12	0	1,030	69.00
69.01	06901	CATH LAB	782	0	21	74	1,770	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,459	4,436	73.00
76.00	03950	DIABETIC EDUCATION	0	0	2	0	8	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,614	239	415	90.00
91.00	09100	EMERGENCY	6,653	8,716	3,169	89	4,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,368	0	231	1,320	553	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,540	37,392	20,290	36,344	42,780	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	44	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	17	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,601	37,392	20,290	36,344	42,780	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	743,641	0	743,641		30.00
31.00	03100	INTENSIVE CARE UNIT	74,350	0	74,350		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	418,021	0	418,021		50.00
50.01	05001	GI LAB	132,612	0	132,612		50.01
50.02	05002	AMBULATORY CARE UNIT	81,504	0	81,504		50.02
51.00	05100	RECOVERY ROOM	21,567	0	21,567		51.00
53.00	05300	ANESTHESIOLOGY	94,881	0	94,881		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	279,088	0	279,088		54.00
60.00	06000	LABORATORY	255,134	0	255,134		60.00
65.00	06500	RESPIRATORY THERAPY	114,855	0	114,855		65.00
66.00	06600	PHYSICAL THERAPY	109,923	0	109,923		66.00
69.00	06900	ELECTROCARDIOLOGY	33,242	0	33,242		69.00
69.01	06901	CATH LAB	66,038	0	66,038		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,598	0	47,598		73.00
76.00	03950	DIABETIC EDUCATION	3,115	0	3,115		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5,752	0	5,752		90.00
91.00	09100	EMERGENCY	224,861	0	224,861		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	19,940	0	19,940		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,726,122	0	2,726,122		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,931	0	4,931		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,186	0	1,186		192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	223	0	223		192.03
192.04	19204	SMART STEPS	0	0	0		192.04
192.05	19205	RESPITE CARE	60	0	60		192.05
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,732,522	0	2,732,522		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	293,311					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,236,020				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,876	0	31,695,433			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,548	27,461	2,397,110	-21,317,979	68,832,242	5.00
7.00	00700	OPERATION OF PLANT	33,701	8,566	283,915	0	3,573,286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	0	0	0	464,927	8.00
9.00	00900	HOUSEKEEPING	4,954	1,075	0	0	1,720,186	9.00
10.00	01000	DIETARY	11,151	8,166	0	0	1,157,905	10.00
11.00	01100	CAFETERIA	9,517	0	0	0	1,336,765	11.00
13.00	01300	NURSING ADMINISTRATION	360	29,144	660,861	0	944,229	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	11,783	85,360	0	517,530	14.00
15.00	01500	PHARMACY	2,341	6,016	1,128,982	0	2,432,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	1,118	1,246,273	0	2,141,269	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,927	194,478	8,882,812	0	11,330,695	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	25,355	1,285,758	0	1,863,957	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,863	228,721	1,911,716	0	7,564,603	50.00
50.01	05001	GI LAB	6,730	68,606	1,079,659	0	2,446,962	50.01
50.02	05002	AMBULATORY CARE UNIT	9,043	10,565	928,574	0	1,677,358	50.02
51.00	05100	RECOVERY ROOM	1,609	5,780	519,252	0	709,835	51.00
53.00	05300	ANESTHESIOLOGY	830	82,814	0	0	797,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	125,794	2,294,606	0	5,207,263	54.00
60.00	06000	LABORATORY	8,547	166,555	1,342,489	0	4,746,672	60.00
65.00	06500	RESPIRATORY THERAPY	8,193	50,829	799,322	0	1,407,612	65.00
66.00	06600	PHYSICAL THERAPY	10,944	16,078	2,230,488	0	3,131,198	66.00
69.00	06900	ELECTROCARDIOLOGY	632	24,801	237,182	0	594,786	69.00
69.01	06901	CATH LAB	600	50,306	421,877	0	1,801,416	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,245,911	73.00
76.00	03950	DIABETIC EDUCATION	406	0	0	0	100,066	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	676,986	90.00
91.00	09100	EMERGENCY	13,214	87,917	2,985,538	0	5,028,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	4,092	945,532	0	2,160,937	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	292,361	1,236,020	31,667,306	-21,317,979	68,780,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	0	0	9,476	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	0	0	0	950	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	22,410	0	33,502	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	5,717	0	7,978	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,505,894	1,226,628	9,708,820		21,317,979	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.134120	0.992401	0.306316		0.309709	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,632		354,245	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000304		0.005146	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	194,186					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	490,585				8.00
9.00	00900	HOUSEKEEPING	4,954	0	186,974			9.00
10.00	01000	DIETARY	11,151	0	11,151	59,726		10.00
11.00	01100	CAFETERIA	9,517	0	9,517	0	42,877	11.00
13.00	01300	NURSING ADMINISTRATION	360	0	360	0	705	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	0	861	0	263	14.00
15.00	01500	PHARMACY	2,341	0	2,341	0	1,600	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	0	4,219	0	2,127	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,927	167,269	54,927	56,488	12,834	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	19,302	4,162	3,238	1,607	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,863	36,204	20,863	0	3,008	50.00
50.01	05001	GI LAB	6,730	44,987	6,730	0	1,428	50.01
50.02	05002	AMBULATORY CARE UNIT	9,043	18,782	9,043	0	1,300	50.02
51.00	05100	RECOVERY ROOM	1,609	17,271	1,609	0	520	51.00
53.00	05300	ANESTHESIOLOGY	830	0	830	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	54,894	16,875	0	3,992	54.00
60.00	06000	LABORATORY	8,547	0	8,547	0	2,519	60.00
65.00	06500	RESPIRATORY THERAPY	8,193	547	8,193	0	1,288	65.00
66.00	06600	PHYSICAL THERAPY	10,944	15,434	10,944	0	3,162	66.00
69.00	06900	ELECTROCARDIOLOGY	632	0	632	0	267	69.00
69.01	06901	CATH LAB	600	7,250	600	0	496	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	406	0	406	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,214	108,645	13,214	0	4,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,502	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	193,236	490,585	186,024	59,726	42,838	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	765	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	0	185	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	28	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	0	11	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,679,965	663,338	2,372,337	1,926,748	2,100,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.100424	1.352137	12.688058	32.259786	48.998041	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	200,000	16,312	40,455	85,212	67,601	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.029940	0.033250	0.216367	1.426715	1.576626	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 7:46 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	423,505					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,098,117				14.00
15.00	01500	PHARMACY	0	5,764	4,240,828			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	385,888,214		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,693	449,446	17,533	26,575,890		30.00
31.00	03100	INTENSIVE CARE UNIT	38,095	111,224	753	3,674,619		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	102,893	685,082	50,484,656		50.00
50.01	05001	GI LAB	0	238,582	6,347	23,058,357		50.01
50.02	05002	AMBULATORY CARE UNIT	0	149,283	5,617	2,148,854		50.02
51.00	05100	RECOVERY ROOM	0	5,422	0	2,778,519		51.00
53.00	05300	ANESTHESIOLOGY	0	77,360	205,956	7,055,956		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	182,972	8,419	82,691,417		54.00
60.00	06000	LABORATORY	0	125,868	2,631	47,441,080		60.00
65.00	06500	RESPIRATORY THERAPY	0	102,815	18,283	13,062,756		65.00
66.00	06600	PHYSICAL THERAPY	0	24,276	1,972	14,395,870		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,279	0	9,275,209		69.00
69.01	06901	CATH LAB	0	2,211	8,634	15,943,643		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,087,314	39,964,406		73.00
76.00	03950	DIABETIC EDUCATION	0	192	0	68,056		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	166,931	27,939	3,742,859		90.00
91.00	09100	EMERGENCY	98,717	327,680	10,362	38,539,663		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	23,919	153,986	4,986,404		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	423,505	2,098,117	4,240,828	385,888,214		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0		192.03
192.04	19204	SMART STEPS	0	0	0	0		192.04
192.05	19205	RESPITE CARE	0	0	0	0		192.05
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,284,453	722,374	3,351,749	3,063,869		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.032911	0.344296	0.790352	0.007940		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,392	20,290	36,344	42,780		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.088292	0.009671	0.008570	0.000111		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 7:46 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	20,787,034		20,787,034	0	20,787,034	30.00
31.00	03100	INTENSIVE CARE UNIT	2,987,255		2,987,255	0	2,987,255	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,849,016		11,849,016	0	11,849,016	50.00
50.01	05001	GI LAB	3,853,435		3,853,435	0	3,853,435	50.01
50.02	05002	AMBULATORY CARE UNIT	2,691,521		2,691,521	0	2,691,521	50.02
51.00	05100	RECOVERY ROOM	1,061,630		1,061,630	0	1,061,630	51.00
53.00	05300	ANESTHESIOLOGY	1,320,599		1,320,599	0	1,320,599	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,436,769		8,436,769	0	8,436,769	54.00
60.00	06000	LABORATORY	7,076,713		7,076,713	0	7,076,713	60.00
65.00	06500	RESPIRATORY THERAPY	2,362,386	0	2,362,386	0	2,362,386	65.00
66.00	06600	PHYSICAL THERAPY	4,803,592	0	4,803,592	0	4,803,592	66.00
69.00	06900	ELECTROCARDIOLOGY	889,414		889,414	0	889,414	69.00
69.01	06901	CATH LAB	2,549,688		2,549,688	0	2,549,688	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,008,583		7,008,583	0	7,008,583	73.00
76.00	03950	DIABETIC EDUCATION	146,599		146,599	0	146,599	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	995,929		995,929	0	995,929	90.00
91.00	09100	EMERGENCY	8,151,892		8,151,892	0	8,151,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,152,023		5,152,023		5,152,023	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,073,324		3,073,324		3,073,324	116.00
200.00		Subtotal (see instructions)	95,197,402	0	95,197,402	0	95,197,402	200.00
201.00		Less Observation Beds	5,152,023		5,152,023		5,152,023	201.00
202.00		Total (see instructions)	90,045,379	0	90,045,379	0	90,045,379	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 7:46 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	21,156,178		21,156,178			30.00
31.00	03100	INTENSIVE CARE UNIT	3,674,619		3,674,619			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,924,434	31,560,222	50,484,656	0.234705	0.000000	50.00
50.01	05001	GI LAB	3,169,178	19,889,179	23,058,357	0.167117	0.000000	50.01
50.02	05002	AMBULATORY CARE UNIT	498,837	1,650,017	2,148,854	1.252538	0.000000	50.02
51.00	05100	RECOVERY ROOM	880,839	1,897,680	2,778,519	0.382085	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,071,885	4,984,071	7,055,956	0.187161	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,711,095	71,980,322	82,691,417	0.102027	0.000000	54.00
60.00	06000	LABORATORY	9,667,527	37,773,553	47,441,080	0.149168	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,638,019	4,424,737	13,062,756	0.180849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,804,288	11,591,582	14,395,870	0.333678	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,559,075	6,716,134	9,275,209	0.095892	0.000000	69.00
69.01	06901	CATH LAB	5,916,296	10,027,347	15,943,643	0.159919	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,084,009	19,880,397	39,964,406	0.175371	0.000000	73.00
76.00	03950	DIABETIC EDUCATION	0	68,056	68,056	2.154094	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,988	3,732,871	3,742,859	0.266088	0.000000	90.00
91.00	09100	EMERGENCY	6,866,725	31,672,938	38,539,663	0.211520	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	802,897	4,616,815	5,419,712	0.950608	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,664	4,983,740	4,986,404			116.00
200.00		Subtotal (see instructions)	118,438,553	267,449,661	385,888,214			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	118,438,553	267,449,661	385,888,214			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 7:46 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.234705		50.00
50.01	05001	GI LAB	0.167117		50.01
50.02	05002	AMBULATORY CARE UNIT	1.252538		50.02
51.00	05100	RECOVERY ROOM	0.382085		51.00
53.00	05300	ANESTHESIOLOGY	0.187161		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102027		54.00
60.00	06000	LABORATORY	0.149168		60.00
65.00	06500	RESPIRATORY THERAPY	0.180849		65.00
66.00	06600	PHYSICAL THERAPY	0.333678		66.00
69.00	06900	ELECTROCARDIOLOGY	0.095892		69.00
69.01	06901	CATH LAB	0.159919		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175371		73.00
76.00	03950	DIABETIC EDUCATION	2.154094		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.266088		90.00
91.00	09100	EMERGENCY	0.211520		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.950608		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 7:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,787,034		20,787,034	0	20,787,034	30.00
31.00	03100	INTENSIVE CARE UNIT	2,987,255		2,987,255	0	2,987,255	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,849,016		11,849,016	0	11,849,016	50.00
50.01	05001	GI LAB	3,853,435		3,853,435	0	3,853,435	50.01
50.02	05002	AMBULATORY CARE UNIT	2,691,521		2,691,521	0	2,691,521	50.02
51.00	05100	RECOVERY ROOM	1,061,630		1,061,630	0	1,061,630	51.00
53.00	05300	ANESTHESIOLOGY	1,320,599		1,320,599	0	1,320,599	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,436,769		8,436,769	0	8,436,769	54.00
60.00	06000	LABORATORY	7,076,713		7,076,713	0	7,076,713	60.00
65.00	06500	RESPIRATORY THERAPY	2,362,386	0	2,362,386	0	2,362,386	65.00
66.00	06600	PHYSICAL THERAPY	4,803,592	0	4,803,592	0	4,803,592	66.00
69.00	06900	ELECTROCARDIOLOGY	889,414		889,414	0	889,414	69.00
69.01	06901	CATH LAB	2,549,688		2,549,688	0	2,549,688	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,008,583		7,008,583	0	7,008,583	73.00
76.00	03950	DIABETIC EDUCATION	146,599		146,599	0	146,599	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	995,929		995,929	0	995,929	90.00
91.00	09100	EMERGENCY	8,151,892		8,151,892	0	8,151,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,152,023		5,152,023		5,152,023	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,073,324		3,073,324		3,073,324	116.00
200.00		Subtotal (see instructions)	95,197,402	0	95,197,402	0	95,197,402	200.00
201.00		Less Observation Beds	5,152,023		5,152,023		5,152,023	201.00
202.00		Total (see instructions)	90,045,379	0	90,045,379	0	90,045,379	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 7:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,156,178		21,156,178			30.00
31.00	03100	INTENSIVE CARE UNIT	3,674,619		3,674,619			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,924,434	31,560,222	50,484,656	0.234705	0.000000	50.00
50.01	05001	GI LAB	3,169,178	19,889,179	23,058,357	0.167117	0.000000	50.01
50.02	05002	AMBULATORY CARE UNIT	498,837	1,650,017	2,148,854	1.252538	0.000000	50.02
51.00	05100	RECOVERY ROOM	880,839	1,897,680	2,778,519	0.382085	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,071,885	4,984,071	7,055,956	0.187161	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,711,095	71,980,322	82,691,417	0.102027	0.000000	54.00
60.00	06000	LABORATORY	9,667,527	37,773,553	47,441,080	0.149168	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,638,019	4,424,737	13,062,756	0.180849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,804,288	11,591,582	14,395,870	0.333678	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,559,075	6,716,134	9,275,209	0.095892	0.000000	69.00
69.01	06901	CATH LAB	5,916,296	10,027,347	15,943,643	0.159919	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,084,009	19,880,397	39,964,406	0.175371	0.000000	73.00
76.00	03950	DIABETIC EDUCATION	0	68,056	68,056	2.154094	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,988	3,732,871	3,742,859	0.266088	0.000000	90.00
91.00	09100	EMERGENCY	6,866,725	31,672,938	38,539,663	0.211520	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	802,897	4,616,815	5,419,712	0.950608	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,664	4,983,740	4,986,404			116.00
200.00		Subtotal (see instructions)	118,438,553	267,449,661	385,888,214			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	118,438,553	267,449,661	385,888,214			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 7:46 pm

Title XIX | Hospital | Cost

		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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	GI LAB	0.000000		50.01
50.02	05002	AMBULATORY CARE UNIT	0.000000		50.02
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CATH LAB	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	DIABETIC EDUCATION	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/23/2017 7:46 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	743,641	0	743,641	15,796	47.08	30.00
31.00	INTENSIVE CARE UNIT	74,350		74,350	1,258	59.10	31.00
43.00	NURSERY	0		0	705	0.00	43.00
200.00	Total (lines 30-199)	817,991		817,991	17,759		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	5,463	257,198	30.00
31.00	INTENSIVE CARE UNIT	589	34,810	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	6,052	292,008	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/23/2017 7:46 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	418,021	50,484,656	0.008280	6,890,460	57,053	50.00
50.01	05001	GI LAB	132,612	23,058,357	0.005751	1,714,817	9,862	50.01
50.02	05002	AMBULATORY CARE UNIT	81,504	2,148,854	0.037929	279,428	10,598	50.02
51.00	05100	RECOVERY ROOM	21,567	2,778,519	0.007762	276,490	2,146	51.00
53.00	05300	ANESTHESIOLOGY	94,881	7,055,956	0.013447	662,199	8,905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	279,088	82,691,417	0.003375	5,617,726	18,960	54.00
60.00	06000	LABORATORY	255,134	47,441,080	0.005378	5,023,000	27,014	60.00
65.00	06500	RESPIRATORY THERAPY	114,855	13,062,756	0.008793	4,900,353	43,089	65.00
66.00	06600	PHYSICAL THERAPY	109,923	14,395,870	0.007636	1,489,312	11,372	66.00
69.00	06900	ELECTROCARDIOLOGY	33,242	9,275,209	0.003584	1,130,479	4,052	69.00
69.01	06901	CATH LAB	66,038	15,943,643	0.004142	2,689,981	11,142	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,598	39,964,406	0.001191	9,496,077	11,310	73.00
76.00	03950	DIABETIC EDUCATION	3,115	68,056	0.045771	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,752	3,742,859	0.001537	2,207	3	90.00
91.00	09100	EMERGENCY	224,861	38,539,663	0.005835	2,984,531	17,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	184,308	5,419,712	0.034007	363,203	12,351	92.00
200.00		Total (lines 50-199)	2,072,499	356,071,013		43,520,263	245,272	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/23/2017 7:46 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
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,796	0.00	5,463	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,258	0.00	589	0		31.00
43.00	04300	NURSERY	705	0.00	0	0		43.00
200.00		Total (lines 30-199)	17,759		6,052	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 7:46 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
50.01	05001	GI LAB	0	0	0	0	0	50.01
50.02	05002	AMBULATORY CARE UNIT	0	0	0	0	0	50.02
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CATH LAB	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 7:46 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	50,484,656	0.000000	0.000000	6,890,460	50.00
50.01	05001	GI LAB	0	23,058,357	0.000000	0.000000	1,714,817	50.01
50.02	05002	AMBULATORY CARE UNIT	0	2,148,854	0.000000	0.000000	279,428	50.02
51.00	05100	RECOVERY ROOM	0	2,778,519	0.000000	0.000000	276,490	51.00
53.00	05300	ANESTHESIOLOGY	0	7,055,956	0.000000	0.000000	662,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,691,417	0.000000	0.000000	5,617,726	54.00
60.00	06000	LABORATORY	0	47,441,080	0.000000	0.000000	5,023,000	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,062,756	0.000000	0.000000	4,900,353	65.00
66.00	06600	PHYSICAL THERAPY	0	14,395,870	0.000000	0.000000	1,489,312	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,275,209	0.000000	0.000000	1,130,479	69.00
69.01	06901	CATH LAB	0	15,943,643	0.000000	0.000000	2,689,981	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,964,406	0.000000	0.000000	9,496,077	73.00
76.00	03950	DIABETIC EDUCATION	0	68,056	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,742,859	0.000000	0.000000	2,207	90.00
91.00	09100	EMERGENCY	0	38,539,663	0.000000	0.000000	2,984,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,419,712	0.000000	0.000000	363,203	92.00
200.00		Total (lines 50-199)	0	356,071,013			43,520,263	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 7:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,194,098	0		50.00
50.01	05001	GI LAB	0	6,272,768	0		50.01
50.02	05002	AMBULATORY CARE UNIT	0	1,063,356	0		50.02
51.00	05100	RECOVERY ROOM	0	363,250	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,104,755	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,735,416	0		54.00
60.00	06000	LABORATORY	0	3,743,828	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,135,889	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,269,807	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,329,318	0		69.00
69.01	06901	CATH LAB	0	4,190,606	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,497,940	0		73.00
76.00	03950	DIABETIC EDUCATION	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,607,973	0		90.00
91.00	09100	EMERGENCY	0	5,864,299	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,939,206	0		92.00
200.00		Total (lines 50-199)	0	61,312,509	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 7:46 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	0.234705	7,194,098	0	7,960	1,688,491	50.00
50.01	05001	GI LAB	0.167117	6,272,768	0	0	1,048,286	50.01
50.02	05002	AMBULATORY CARE UNIT	1.252538	1,063,356	0	0	1,331,894	50.02
51.00	05100	RECOVERY ROOM	0.382085	363,250	0	0	138,792	51.00
53.00	05300	ANESTHESIOLOGY	0.187161	1,104,755	0	0	206,767	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102027	17,735,416	0	16,112	1,809,491	54.00
60.00	06000	LABORATORY	0.149168	3,743,828	0	0	558,459	60.00
65.00	06500	RESPIRATORY THERAPY	0.180849	1,135,889	0	0	205,424	65.00
66.00	06600	PHYSICAL THERAPY	0.333678	1,269,807	0	0	423,707	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095892	2,329,318	0	0	223,363	69.00
69.01	06901	CATH LAB	0.159919	4,190,606	0	577	670,158	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175371	5,497,940	0	44,768	964,179	73.00
76.00	03950	DIABETIC EDUCATION	2.154094	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.266088	1,607,973	0	1,780	427,862	90.00
91.00	09100	EMERGENCY	0.211520	5,864,299	0	0	1,240,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.950608	1,939,206	0	0	1,843,425	92.00
200.00		Subtotal (see instructions)		61,312,509	0	71,197	12,780,715	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		61,312,509	0	71,197	12,780,715	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 7:46 pm

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		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	1,868		50.00
50.01	05001	GI LAB	0	0		50.01
50.02	05002	AMBULATORY CARE UNIT	0	0		50.02
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,644		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CATH LAB	0	92		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,851		73.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	474		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	11,929		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	11,929		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 7:46 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)	15,796	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,796	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)	11,881	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)	5,463	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)	20,787,034	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)	20,787,034	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)	20,787,034	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)	1,315.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,189,144	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)	7,189,144	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 7:46 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,987,255	1,258	2,374.61	589	1,398,645	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)	8,370,040	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,957,829	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)	292,008	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	245,272	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	537,280	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,420,549	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)	3,915	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,315.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,152,023	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 7:46 pm

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	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	743,641	20,787,034	0.035774	5,152,023	184,308	90.00
91.00	Nursing School cost	0	20,787,034	0.000000	5,152,023	0	91.00
92.00	Allied health cost	0	20,787,034	0.000000	5,152,023	0	92.00
93.00	All other Medical Education	0	20,787,034	0.000000	5,152,023	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 7:46 pm

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		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		7,562,701		30.00
31.00	03100	INTENSIVE CARE UNIT		1,618,910		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.234705	6,890,460	1,617,225	50.00
50.01	05001	GI LAB	0.167117	1,714,817	286,575	50.01
50.02	05002	AMBULATORY CARE UNIT	1.252538	279,428	349,994	50.02
51.00	05100	RECOVERY ROOM	0.382085	276,490	105,643	51.00
53.00	05300	ANESTHESIOLOGY	0.187161	662,199	123,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102027	5,617,726	573,160	54.00
60.00	06000	LABORATORY	0.149168	5,023,000	749,271	60.00
65.00	06500	RESPIRATORY THERAPY	0.180849	4,900,353	886,224	65.00
66.00	06600	PHYSICAL THERAPY	0.333678	1,489,312	496,951	66.00
69.00	06900	ELECTROCARDIOLOGY	0.095892	1,130,479	108,404	69.00
69.01	06901	CATH LAB	0.159919	2,689,981	430,179	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175371	9,496,077	1,665,337	73.00
76.00	03950	DIABETIC EDUCATION	2.154094	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.266088	2,207	587	90.00
91.00	09100	EMERGENCY	0.211520	2,984,531	631,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.950608	363,203	345,264	92.00
200.00		Total (sum of lines 50-94 and 96-98)		43,520,263	8,370,040	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)		43,520,263		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/23/2017 7:46 pm
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		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)	8,193,564	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,767,552	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)	194,457	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)	89.30	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.46	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.70	31.00
32.00	Sum of lines 30 and 31	23.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.32	33.00
34.00	Disproportionate share adjustment (see instructions)	227,991	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/23/2017 7:46 pm
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		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)	604,435	551,211	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	452,501	138,935	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	591,436		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)	11,975,000		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	12,444,841		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	12,327,381	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	881,346	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)	13,208,727	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	13,208,727	61.00
62.00	Deductibles billed to program beneficiaries	1,457,652	62.00
63.00	Coinsurance billed to program beneficiaries	2,254	63.00
64.00	Allowable bad debts (see instructions)	429,034	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	278,872	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	367,045	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	12,027,693	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)	-1,037	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-3,419	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-32,354	70.93
70.94	HRR adjustment amount (see instructions)	-106,378	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/23/2017 7:46 pm
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		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)		11,884,505	71.00
71.01	Sequestration adjustment (see instructions)		237,690	71.01
72.00	Interim payments		11,635,118	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)		11,697	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	263,804	88,577	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.9986222680	0.9923883520	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-363	-674	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9908	0.9888	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-2,427	-992	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/23/2017 7:46 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,193,564	0	8,193,564		8,193,564	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,767,552	0		2,767,552	2,767,552	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	194,457	0	138,821	55,636	194,457	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0832	0.0832	0.0832	0.0832		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	227,991	0	170,426	57,565	227,991	11.00
11.01	Uncompensated care payments	36.00	591,436	237,096	0	0	237,096	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,975,000	237,096	8,857,151	2,880,753	11,975,000	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,444,841	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,327,381	237,096	9,209,532	2,880,753	12,327,381	15.00
16.00	Payment for inpatient program capital	50.00	881,346	0	656,952	224,394	881,346	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/23/2017 7:46 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			237,096	9,866,484	3,105,147	13,208,727	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	879,754	0	655,942	223,812	879,754	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,592	0	1,010	582	1,592	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	881,346	0	656,952	224,394	881,346	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2017 7:46 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,193,564	8,193,564		8,193,564	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,767,552		2,767,552	2,767,552	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	194,457	138,821	55,636	194,457	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0832	0.0832	0.0832		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	227,991	170,426	57,565	227,991	11.00
11.01	Uncompensated care payments	36.00	591,436	452,501	138,935	591,436	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,975,000	8,955,312	3,019,688	11,975,000	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,444,841	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,327,381	9,307,693	3,019,688	12,327,381	15.00
16.00	Payment for inpatient program capital	50.00	881,346	656,952	224,394	881,346	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,964,645	3,244,082	13,208,727	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2017 7:46 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	879,754	655,942	223,812	879,754	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,592	1,010	582	1,592	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	881,346	656,952	224,394	881,346	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-32,354	-11,289	-21,065	-32,354	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-1,037	-363	-674	-1,037	30.01
31.00	HRR adjustment (see instructions)	70.94	-106,378	-75,381	-30,997	-106,378	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-3,419	-2,427	-992	-3,419	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/23/2017 7:46 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,929	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,780,715	2.00
3.00	PPS payments	9,699,171	3.00
4.00	Outlier payment (see instructions)	39,012	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.822	5.00
6.00	Line 2 times line 5	10,505,748	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	92.69	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)	11,929	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	71,197	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)	71,197	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)	71,197	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	59,268	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)	11,929	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)	9,738,183	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,995,754	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)	7,754,358	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)	7,754,358	30.00
31.00	Primary payer payments	1,491	31.00
32.00	Subtotal (line 30 minus line 31)	7,752,867	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)	451,674	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	293,588	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	391,665	36.00
37.00	Subtotal (see instructions)	8,046,455	37.00
38.00	MSP-LCC reconciliation amount from PS&R	444	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)	8,046,011	40.00
40.01	Sequestration adjustment (see instructions)	160,920	40.01
41.00	Interim payments	7,974,081	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-88,990	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/23/2017 7:46 pm

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		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		11,635,118		7,925,304	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	08/18/2016	48,777	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		48,777	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)		11,635,118		7,974,081	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		11,697		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		88,990	6.02
7.00	Total Medicare program liability (see instructions)		11,646,815		7,885,091	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: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/23/2017 7:46 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	3,827	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,052	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,987	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	13,139	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	385,888,214	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,770,346	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/23/2017 7:46 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	4,832,101	0	0	0	1.00
2.00	Temporary investments	11,544,699	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,008,093	0	0	0	4.00
5.00	Other receivable	1,260,713	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,208,394	0	0	0	9.00
10.00	Due from other funds	784,568	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	48,638,568	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,796,138	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,796,138	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,160,839	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,559,317	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,720,156	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,154,862	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,611,345	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,424,816	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,472,234	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,508,395	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	6,175,815	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,175,815	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,684,210	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	44,470,652				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)	44,470,652	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,154,862	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/23/2017 7:46 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		47,664,478		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,573,864				2.00
3.00	Total (sum of line 1 and line 2)		44,090,614		0		3.00
4.00	PRIOR PERIOD ADJUSTMENT	380,038		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)		380,038		0		10.00
11.00	Subtotal (line 3 plus line 10)		44,470,652		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	0		0		0	12.00
13.00	ROUNDING	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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,470,652		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	PRIOR PERIOD ADJUSTMENT		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	PRIOR PERIOD ADJUSTMENT		0		12.00
13.00	ROUNDING		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: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2017 7:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	33,140,583		33,140,583	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	33,140,583		33,140,583	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,674,619		3,674,619	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)	3,674,619		3,674,619	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	36,815,202		36,815,202	17.00
18.00	Ancillary services	88,760,454	236,366,935	325,127,389	18.00
19.00	Outpatient services	9,400,853	50,012,031	59,412,884	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	2,664	4,983,740	4,986,404	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)	134,979,173	291,362,706	426,341,879	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		103,870,039		29.00
30.00	ROUNDING	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	FMH GEN/OVHD HFS ACA SUPP PYMTS	2,960,514			37.00
38.00	ROUNDING	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)		2,960,514		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		100,909,525		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0160 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/23/2017 7:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	426,341,879	1.00
2.00	Less contractual allowances and discounts on patients' accounts	297,094,123	2.00
3.00	Net patient revenues (line 1 minus line 2)	129,247,756	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	100,909,525	4.00
5.00	Net income from service to patients (line 3 minus line 4)	28,338,231	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAID ASSESSMENT	6,258,760	24.00
24.01	GAIN ON SALE	122,387	24.01
24.02	OTHER OP REV	467,551	24.02
24.03	NET ASSETS	143,649	24.03
24.04	INVESTMENT INCOME	280,621	24.04
24.05	NET PENSION COSTS CHANGE	25,456,489	24.05
24.06	CONTRIBUTIONS	83,212	24.06
25.00	Total other income (sum of lines 6-24)	32,812,669	25.00
26.00	Total (line 5 plus line 25)	61,150,900	26.00
27.00	TRANSFER TO OTHER AFFILIATES	29,296,165	27.00
27.01	CHARITY CARE	2,995,132	27.01
27.02	ROUNDING	3	27.02
27.03	CHANGE IN MALPRACTICE LIABILITY	25,443,837	27.03
27.05	BAD DEBTS	6,930,245	27.05
27.06	LOSS ON PENSION PLAN TERMINATION	59,382	27.06
28.00	Total other expenses (sum of line 27 and subscripts)	64,724,764	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,573,864	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0160 | Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O | Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1,208	1,208	0	1,208	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	121,604	121,604	0	121,604	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	187	187	0	187	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	57,924	57,924	0	57,924	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	32,313	0	32,313	0	32,313	13.00
14.00	PHARMACY*	0	153,986	153,986	0	153,986	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	197,818	24,833	222,651	0	222,651	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	1,950	0	1,950	0	1,950	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	468,965	557,880	1,026,845	0	1,026,845	28.00
29.00	LPN/LVN**	115,647	0	115,647	0	115,647	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	96,984	0	96,984	0	96,984	33.00
34.00	SPIRITUAL COUNSELING**	31,607	0	31,607	0	31,607	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	22,161	22,161	0	22,161	38.00
39.00	PATIENT TRANSPORTATION**	0	6,764	6,764	0	6,764	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	246	0	246	0	246	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	945,530	946,547	1,892,077	0	1,892,077	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0160 | Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O | Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1,208		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	121,604		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	187		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	57,924		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	32,313		13.00
14.00	PHARMACY*	0	153,986		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	-24,833	197,818		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	1,950		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	1,026,845		28.00
29.00	LPN/LVN**	0	115,647		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	96,984		33.00
34.00	SPIRITUAL COUNSELING**	0	31,607		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	22,161		38.00
39.00	PATIENT TRANSPORTATION**	0	6,764		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	246		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-24,833	1,867,244		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0160 Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-2 Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	1,948	0	1,948	0	1,948	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	468,457	557,275	1,025,732	0	1,025,732	28.00
29.00	LPN/LVN	115,522	0	115,522	0	115,522	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	96,879	0	96,879	0	96,879	33.00
34.00	SPIRITUAL COUNSELING	31,573	0	31,573	0	31,573	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	22,161	22,161	0	22,161	38.00
39.00	PATIENT TRANSPORTATION	0	6,756	6,756	0	6,756	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	246	0	246	0	246	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	714,625	586,192	1,300,817	0	1,300,817	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	1,948		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,025,732		28.00
29.00	LPN/LVN	0	115,522		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	96,879		33.00
34.00	SPIRITUAL COUNSELING	0	31,573		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	22,161		38.00
39.00	PATIENT TRANSPORTATION	0	6,756		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	246		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,300,817		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-0160 Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-3 Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	2	0	2	0	2	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	391	465	856	0	856	28.00
29.00	LPN/LVN	96	0	96	0	96	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	81	0	81	0	81	33.00
34.00	SPIRITUAL COUNSELING	26	0	26	0	26	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	6	6	0	6	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	596	471	1,067	0	1,067	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	2		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	856		28.00
29.00	LPN/LVN	0	96		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	81		33.00
34.00	SPIRITUAL COUNSELING	0	26		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	6		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,067		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 14-0160 Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-4 | Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	117	140	257	0	257	28.00
29.00	LPN/LVN	29	0	29	0	29	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	24	0	24	0	24	33.00
34.00	SPIRITUAL COUNSELING	8	0	8	0	8	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	2	2	0	2	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	178	142	320	0	320	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	257		28.00
29.00	LPN/LVN	0	29		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	24		33.00
34.00	SPIRITUAL COUNSELING	0	8		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	2		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	320		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0160 Hospice CCN: 14-1560

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

Worksheet O-5

Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,061	4,061	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	1,208	289,632	290,840	3.00
4.00	ADMINISTRATIVE & GENERAL	121,604	742,857	864,461	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	187	8,235	8,422	10.00
11.00	MEDICAL RECORDS	0	39,592	39,592	11.00
12.00	STAFF TRANSPORTATION	57,924		57,924	12.00
13.00	VOLUNTEER SERVICE COORDINATION	32,313		32,313	13.00
14.00	PHARMACY	153,986	121,703	275,689	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	197,818	0	197,818	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,300,817		1,300,817	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,067		1,067	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	320		320	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,867,244	1,206,080	3,073,324	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0160 Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,061		4,061			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	290,840	0	0	290,840		3.00
4.00	ADMINISTRATIVE & GENERAL	864,461	0	0	0	864,461	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	8,422	0	0	0	8,422	10.00
11.00	MEDICAL RECORDS	39,592	0	0	0	39,592	11.00
12.00	STAFF TRANSPORTATION	57,924	0	0	0	57,924	12.00
13.00	VOLUNTEER SERVICE COORDINATION	32,313	0	0	0	32,313	13.00
14.00	PHARMACY	275,689	0	0	0	275,689	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	197,818	0	0	0	197,818	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,300,817			290,541	1,591,358	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,067	0	3,124	230	4,421	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	320	0	937	69	1,326	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,073,324	0	4,061	290,840	3,073,324	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0160 Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	864,461					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,296	0		0		10.00
11.00	MEDICAL RECORDS	15,495	0		0		11.00
12.00	STAFF TRANSPORTATION	22,669	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	12,646	0		0		13.00
14.00	PHARMACY	107,894	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	77,418	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	622,794					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,730	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	519	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	864,461	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0160 | Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I | Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	11,718				10.00
11.00	MEDICAL RECORDS	0		55,087			11.00
12.00	STAFF TRANSPORTATION	0			80,593		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	44,959	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	11,706	55,031	80,510	44,913	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	9	43	64	35	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	3	13	19	11	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	11,718	55,087	80,593	44,959	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0160 Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	383,583					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		275,236			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	383,189	0	274,954		3,064,455	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	303	0	217	0	6,822	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	91	0	65	0	2,047	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	383,583	0	275,236	0	3,073,324	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160
Hospice CCN: 14-1560

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

Worksheet O-6
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	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		13				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,670			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-864,461	2,208,863	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	8,422	10.00
11.00	MEDICAL RECORDS	0	0	0	0	39,592	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	57,924	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	32,313	13.00
14.00	PHARMACY	0	0	0	0	275,689	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	197,818	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			12,657	0	1,591,358	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	10	10	0	4,421	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	3	3	0	1,326	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	4,061	290,840		864,461	100.00
101.00	UNIT COST MULTIPLIER	0.000000	312.384615	22.955012		0.391360	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160
Hospice CCN: 14-1560

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160
Hospice CCN: 14-1560

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

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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	12,670					10.00
11.00	MEDICAL RECORDS		12,670				11.00
12.00	STAFF TRANSPORTATION			12,670			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	12,670		13.00
14.00	PHARMACY			0	0	12,670	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	12,657	12,657	12,657	12,657	12,657	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	10	10	10	10	10	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3	3	3	3	3	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	11,718	55,087	80,593	44,959	383,583	100.00
101.00	UNIT COST MULTIPLIER	0.924862	4.347830	6.360931	3.548461	30.274901	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160
Hospice CCN: 14-1560

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

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	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	12,670				15.00
16.00	OTHER GENERAL SERVICE		12,670			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	12,657	12,657			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	10	10	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3	3	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	275,236	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	21.723441	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0160 Hospice CCN: 14-1560

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

Worksheet O-7

Date/Time Prepared: 5/23/2017 7:46 pm

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	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.333678	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.175371	0	181,996	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.149168	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.000000	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	DIABETIC EDUCATION	76.00	2.154094	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	31,917	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	DIABETIC EDUCATION	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	31,917	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0160 | Hospice CCN: 14-1560 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-8 | Date/Time Prepared: 5/23/2017 7:46 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			3,096,372	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			12,657	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			244.64	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	11,961	184		9.00
10.00	Program cost (line 8 times line 9)	2,926,139	45,014		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			6,822	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			10	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			682.20	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	10	0		14.00
15.00	Program cost (line 13 times line 14)	6,822	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			2,047	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			3	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			682.33	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	3	0		19.00
20.00	Program cost (line 18 times line 19)	2,047	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,105,241	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			12,670	22.00
23.00	Average cost per diem (line 21 divided by line 22)			245.09	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0160	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/23/2017 7:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	879,754	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,592	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)	36.19	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	881,346	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