

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 12:16 pm
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**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only  
 5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

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

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

Date: 5/30/2018 Time: 12:16 pm

**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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL SOUTH ( 15-0128 ) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	183,137	236,923	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	0		0	6.00
200.00 Total	0	183,137	236,923	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 10:44 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH	PO Box:	Zip Code: 46227		County: MARI ON				1.00	
2.00	City: INDIANAPOLIS	State: IN							2.00	
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2017	12/31/2017		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	852	353	3	8	7,381	24		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 10:44 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (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)(i) or (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		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) 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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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)					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)					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)					61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						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)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
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 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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)						64.00	0.00 0.00 0.000000

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	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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	2.68	0.000000		66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.00	1.86	0.000000		67.00
					1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS 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 is 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
75.00	Inpatient Rehabilitation Facility PPS 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 is 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

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			1.00			
<b>Long Term Care Hospital PPS</b>						
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		
<b>TEFRA Providers</b>						
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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 2.00		
<b>Title V and XIX Services</b>						
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	
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	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 10:44 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	589,337	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? 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
<b>Transplant Center Information</b>						
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
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
<b>All Providers</b>						
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		HB0720		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

1.00		2.00				3.00							
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.												
141.00	Name: COMMUNITY HEALTH NETWORK		Contractor's Name: WISCONSIN PHYSICIANS SERVICES				Contractor's Number: 08101				141.00		
142.00	Street: 1500 NORTH RITTER AVENUE		PO Box:		State: IN		Zip Code: 46219-3095				142.00		
143.00	City: INDIANAPOLIS										143.00		
										1.00			
144.00	Are provider based physicians' costs included in Worksheet A?										Y	144.00	
										1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.										Y	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.										N	146.00	
										1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.										N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.										N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.										N	149.00	
		Part A		Part B		Title V		Title XIX					
		1.00		2.00		3.00		4.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)													
155.00	Hospital		N		N		N		N		155.00		
156.00	Subprovider - IPF		N		N		N		N		156.00		
157.00	Subprovider - IRF		N		N		N		N		157.00		
158.00	SUBPROVIDER										158.00		
159.00	SNF		N		N		N		N		159.00		
160.00	HOME HEALTH AGENCY		N		N		N		N		160.00		
161.00	CMHC		N		N		N		N		161.00		
										1.00			
Multi campus													
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.										N	165.00	
		Name		County		State		Zip Code		CBSA		FTE/Campus	
		0		1.00		2.00		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)										0.00	166.00	
										1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.										Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)										0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)											168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)										9.99	169.00	
						Beginnig		Endng					
						1.00		2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)										01/01/2015	12/31/2015	170.00
										1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)										N	0	171.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 10:44 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/29/2014	Y	04/29/2014		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 10:44 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		N		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		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD	HELMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501	RHELMS@COMMUNITY.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 10:44 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	158	57,670	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)		158	57,670	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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)		170	62,050	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		170				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
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

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)	13,325	737	33,671			1.00
2.00	HMO and other (see instructions)	5,051	6,349				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	13,325	737	33,671			7.00
8.00	INTENSIVE CARE UNIT	1,043	0	2,777			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		1,511	3,224			13.00
14.00	Total (see instructions)	14,368	2,248	39,672	7.06	859.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	609			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)				7.06	859.55	27.00
28.00	Observation Bed Days		886	4,425			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			527			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	24	659			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,514	126	9,845	1.00
2.00 HMO and other (see instructions)			1,090	1,491		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	3,514	126	9,845	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet S-3 Part II Date/Time Prepared: 5/30/2018 10:44 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. 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		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	59,255,377	-352,869	58,902,508	1,787,873.00	32.95	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		314,070	0	314,070	1,972.00	159.26	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		253,585	0	253,585	4,128.00	61.43	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)		409,025	-5,909	403,116	17,661.00	22.83	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract Labor: Direct Patient Care		705,263	0	705,263	7,881.00	89.49	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		2,232,082	0	2,232,082	26,556.00	84.05	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		16,767,337	0	16,767,337	427,007.00	39.27	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		65,884	0	65,884	323.00	203.98	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		14,316,934	0	14,316,934			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		105,554	0	105,554			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		19,409	0	19,409			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		40,629	0	40,629			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 (core)		4,234,650	0	4,234,650			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	441,292	0	441,292	3,052.00	144.59	26.00
27.00	Administrative & General	5.00	4,312,947	-4,365	4,308,582	96,592.00	44.61	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2018 10:44 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	6,793,083	0	6,793,083	60,154.00	112.93	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,509,342	-2,304	1,507,038	68,877.00	21.88	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,345,344	-4,793	1,340,551	92,042.00	14.56	32.00
33.00	Housekeeping under contract (see instructions)	317,417	0	317,417	6,476.00	49.01	33.00
34.00	Dietary	1,204,595	-826,656	377,939	23,171.00	16.31	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	817,264	817,264	48,891.00	16.72	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	258,470	-209	258,261	17,288.00	14.94	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	236,517	-4,817	231,700	5,910.00	39.20	41.00
42.00	Social Service	1,189,775	-4,044	1,185,731	32,198.00	36.83	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2018 10:44 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	66,112,292	-352,869	65,759,423	1,850,375.00	35.54	1.00
2.00	Excluded area salaries (see instructions)	409,025	-5,909	403,116	17,661.00	22.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)	65,703,267	-346,960	65,356,307	1,832,714.00	35.66	3.00
4.00	Subtotal other wages & related costs (see inst.)	19,770,566	0	19,770,566	461,767.00	42.82	4.00
5.00	Subtotal wage-related costs (see inst.)	18,570,993	0	18,570,993	0.00	28.41	5.00
6.00	Total (sum of lines 3 thru 5)	104,044,826	-346,960	103,697,866	2,294,481.00	45.19	6.00
7.00	Total overhead cost (see instructions)	17,608,782	-29,924	17,578,858	454,651.00	38.66	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet S-3  
Part IV  
Date/Time Prepared:  
5/30/2018 10:44 am

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	1,705,451	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	5,434,854	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,324,240	9.00
10.00	Dental, Hearing and Vision Plan	49,784	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,222	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)	523,166	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	116,221	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	4,232,592	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	59,995	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,482,525	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/30/2018 10:44 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	705,263	14,482,525	1.00
2.00	Hospital	705,263	14,376,971	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	105,554	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/30/2018 10:44 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.206550	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		17,129,807	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 and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		144,714,798	6.00
7.00	Medicaid cost (line 1 times line 6)		29,890,842	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)		12,761,035	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		12,761,035	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,354,770	1,732,464	3,087,234
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	279,828	1,732,464	2,012,292
22.00	Payments received from patients for amounts previously written off as charity care	0	22,722	22,722
23.00	Cost of charity care (line 21 minus line 22)	279,828	1,709,742	1,989,570
			1.00	
24.00	Does the amount on 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, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		49,744,032	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		294,905	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		453,700	27.01
28.00	Non-Medicare bad debt expense (see instructions)		49,290,332	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		10,339,713	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		12,329,283	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		25,090,318	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		0	0	8,700,536	8,700,536	1.00
2.00	00200		0	0	6,183,669	6,183,669	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	441,292	57,185	498,477	-71	498,406	4.00
5.00	00500	4,312,947	62,414,320	66,727,267	-7,849,255	58,878,012	5.00
7.00	00700	1,509,342	3,312,313	4,821,655	-50,212	4,771,443	7.00
8.00	00800	0	636,440	636,440	0	636,440	8.00
9.00	00900	1,345,344	833,403	2,178,747	-17,430	2,161,317	9.00
10.00	01000	1,204,595	865,620	2,070,215	-1,429,663	640,552	10.00
11.00	01100	0	0	0	1,351,561	1,351,561	11.00
13.00	01300	258,470	60,983	319,453	0	319,453	13.00
16.00	01600	236,517	69,609	306,126	-73	306,053	16.00
17.00	01700	1,189,775	374,409	1,564,184	-2,276	1,561,908	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	20,807,829	9,293,859	30,101,688	-4,851,458	25,250,230	30.00
31.00	03100	2,548,041	1,258,836	3,806,877	-400,408	3,406,469	31.00
43.00	04300	0	0	0	966,385	966,385	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,070,649	17,221,401	20,292,050	-14,308,712	5,983,338	50.00
51.00	05100	2,576,080	1,156,142	3,732,222	-114,629	3,617,593	51.00
52.00	05200	584,600	100,003	684,603	2,544,240	3,228,843	52.00
54.00	05400	1,700,436	1,686,787	3,387,223	-795,813	2,591,410	54.00
55.00	05500	555,336	1,201,786	1,757,122	-1,054,370	702,752	55.00
57.00	05700	540,585	1,017,973	1,558,558	-310,970	1,247,588	57.00
58.00	05800	216,707	535,139	751,846	-144,611	607,235	58.00
59.00	05900	1,248,970	6,979,808	8,228,778	-6,281,701	1,947,077	59.00
60.00	06000	0	6,277,421	6,277,421	-18,231	6,259,190	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,702,510	1,079,672	2,782,182	-537,726	2,244,456	65.00
66.00	06600	2,033,026	1,041,114	3,074,140	-1,152,880	1,921,260	66.00
67.00	06700	0	0	0	596,660	596,660	67.00
68.00	06800	0	0	0	158,536	158,536	68.00
69.00	06900	801,936	428,000	1,229,936	-98,466	1,131,470	69.00
70.00	07000	393,453	364,693	758,146	-135,002	623,144	70.00
71.00	07100	0	762,335	762,335	9,958,250	10,720,585	71.00
72.00	07200	0	0	0	10,365,142	10,365,142	72.00
73.00	07300	2,528,374	8,846,723	11,375,097	191,889	11,566,986	73.00
74.00	07400	0	468,415	468,415	-751	467,664	74.00
76.00	03950	620,412	1,323,722	1,944,134	-602,286	1,341,848	76.00
76.06	03330	728,111	1,391,371	2,119,482	-559,324	1,560,158	76.06
76.97	07697	198,452	74,403	272,855	-5,928	266,927	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	0	0	0	0	0	90.01
90.02	04951	513,437	170,835	684,272	-16,920	667,352	90.02
90.03	04952	0	0	0	0	0	90.03
90.04	04953	144,446	98,541	242,987	-30,633	212,354	90.04
91.00	09100	4,834,680	2,654,641	7,489,321	-185,409	7,303,912	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		58,846,352	134,057,902	192,904,254	61,660	192,965,914	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	455	191,450	191,905	-50,907	140,998	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	0	0	0	194.06
194.08	07958	408,570	119,793	528,363	-10,753	517,610	194.08
200.00		59,255,377	134,369,145	193,624,522	0	193,624,522	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,371,650	7,328,886	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,391,008	9,574,677	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,201,853	2,700,259	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-22,278,334	36,599,678	5.00
7.00	00700	OPERATION OF PLANT	562,598	5,334,041	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	636,440	8.00
9.00	00900	HOUSEKEEPING	0	2,161,317	9.00
10.00	01000	DIETARY	-10,551	630,001	10.00
11.00	01100	CAFETERIA	-102,443	1,249,118	11.00
13.00	01300	NURSING ADMINISTRATION	2,196,337	2,515,790	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,532,560	1,838,613	16.00
17.00	01700	SOCIAL SERVICE	0	1,561,908	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	524,946	524,946	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	949,776	949,776	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	696,784	25,947,014	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,406,469	31.00
43.00	04300	NURSERY	0	966,385	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	5,983,338	50.00
51.00	05100	RECOVERY ROOM	0	3,617,593	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-14,500	3,214,343	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-352,643	2,238,767	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	702,752	55.00
57.00	05700	CT SCAN	0	1,247,588	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	607,235	58.00
59.00	05900	CARDIAC CATHETERIZATION	-12,939	1,934,138	59.00
60.00	06000	LABORATORY	-791,438	5,467,752	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,244,456	65.00
66.00	06600	PHYSICAL THERAPY	-35,027	1,886,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	596,660	67.00
68.00	06800	SPEECH PATHOLOGY	0	158,536	68.00
69.00	06900	ELECTROCARDIOLOGY	125,802	1,257,272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,444	723,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016,738	11,737,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,365,142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	338,273	11,905,259	73.00
74.00	07400	RENAL DIALYSIS	0	467,664	74.00
76.00	03950	ENDOSCOPY	0	1,341,848	76.00
76.06	03330	IMAGING CENTER	0	1,560,158	76.06
76.97	07697	CARDIAC REHABILITATION	-10,288	256,639	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	-313,943	353,409	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	212,354	90.04
91.00	09100	EMERGENCY	0	7,303,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,656,637	181,309,277	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	140,998	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	517,610	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,656,637	181,967,885	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>A - Chargeable Medical Supplies</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,928,461	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
TOTALS			0	10,928,461	
<b>B - Implantable Device Recl ass</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,365,142	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
TOTALS			0	10,365,142	
<b>C - Drugs Charges to Pat</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00		509,046	1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
12.00					12.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00					17.00
18.00					18.00
19.00					19.00
			0	509,046	
<b>D - Depreciation Expense</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,072,209	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-6

Date/Time Prepared:  
5/30/2018 10:44 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	TOTALS		0	9,072,209	
E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,582,565	1.00
	TOTALS		0	3,582,565	
F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,999,330	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	543	2.00
3.00	EMERGENCY	91.00	0	4,507	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	TOTALS		0	2,004,380	
G - STD BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,365	1.00
2.00	OPERATION OF PLANT	7.00	0	2,304	2.00
3.00	HOUSEKEEPING	9.00	0	4,793	3.00
4.00	DIETARY	10.00	0	9,392	4.00
5.00	NURSING ADMINISTRATION	13.00	0	209	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,817	6.00
7.00	SOCIAL SERVICE	17.00	0	4,044	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	171,126	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	18,487	9.00
10.00	OPERATING ROOM	50.00	0	22,095	10.00
11.00	RECOVERY ROOM	51.00	0	20,796	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,278	12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,659	13.00
14.00	CT SCAN	57.00	0	339	14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	177	15.00
16.00	RESPIRATORY THERAPY	65.00	0	10,734	16.00
17.00	PHYSICAL THERAPY	66.00	0	5,551	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	6,631	18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,253	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,013	20.00
21.00	ENDOSCOPY	76.00	0	1,764	21.00
22.00	IMAGING CENTER	76.06	0	2,122	22.00
23.00	CARDIAC REHABILITATION	76.97	0	2,572	23.00
24.00	ANTI-COAGULATION CLINIC	90.02	0	197	24.00
25.00	EMERGENCY	91.00	0	25,242	25.00
26.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	5,909	26.00
	TOTALS		0	352,869	
H - Labor and Delivery					
1.00	NURSERY	43.00	663,264	303,121	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,746,201	798,039	2.00
			2,409,465	1,101,160	
I - Cafeteria					
1.00	CAFETERIA	11.00	817,264	534,297	1.00
	TOTALS		817,264	534,297	



RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-6

Date/Time Prepared:  
5/30/2018 10:44 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>J - Therapy</b>					
1.00	OCCUPATIONAL THERAPY	67.00	453,038	143,622	1.00
2.00	SPEECH PATHOLOGY	68.00	120,375	38,161	2.00
			573,413	181,783	
<b>K - BUILDING DEPRECIATION</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,887,870	1.00
	TOTALS		0	4,887,870	
<b>L - Capital Insurance Costs</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	230,101	1.00
	TOTALS		0	230,101	
<b>M - RADIOLOGY SUPPORT STAFF</b>					
1.00	RADIOLOGY-THERAPEUTIC	55.00	66,299	38,227	1.00
2.00	CT SCAN	57.00	154,903	89,313	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	30,958	17,850	3.00
			252,160	145,390	
500.00	Grand Total: Increases		4,052,302	43,895,273	500.00

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-6  
Date/Time Prepared:  
5/30/2018 10:44 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>A - Chargeable Medical Supplies</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	706,522	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	180,308	0		2.00
3.00	OPERATING ROOM	50.00	0	6,037,675	0		3.00
4.00	RECOVERY ROOM	51.00	0	52,704	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,304	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	846,068	0		6.00
7.00	CT SCAN	57.00	0	128,897	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,883	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	2,204,569	0		9.00
10.00	LABORATORY	60.00	0	15,978	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	403,495	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	27	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	47	0		13.00
14.00	ENDOSCOPY	76.00	0	235,557	0		14.00
15.00	IMAGING CENTER	76.06	0	30,287	0		15.00
16.00	EMERGENCY	91.00	0	76,140	0		16.00
TOTALS			0	10,928,461			
<b>B - Implantable Device Recl ass</b>							
1.00	OPERATING ROOM	50.00	0	6,994,336	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	281,878	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	3,080,686	0		3.00
4.00	ENDOSCOPY	76.00	0	8,242	0		4.00
TOTALS			0	10,365,142			
<b>C - Drugs Charges to Pat</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00		22			1.00
2.00	ADULTS & PEDIATRICS	30.00		88,698			2.00
3.00	INTENSIVE CARE UNIT	31.00		13,471			3.00
4.00	OPERATING ROOM	50.00		29,703			4.00
5.00	RECOVERY ROOM	51.00		7,928			5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00		24,796			6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00		855			7.00
8.00	CT SCAN	57.00		133,414			8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		48,937			9.00
10.00	CARDIAC CATHETERIZATION	59.00		49,044			10.00
11.00	RESPIRATORY THERAPY	65.00		9,288			11.00
12.00	PHYSICAL THERAPY	66.00		1,078			12.00
13.00	ELECTROCARDIOLOGY	69.00		928			13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00		512			14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		3,311			15.00
16.00	RENAL DIALYSIS	74.00		703			16.00
17.00	ENDOSCOPY	76.00		8,524			17.00
18.00	IMAGING CENTER	76.06		66,709			18.00
19.00	EMERGENCY	91.00		21,125			19.00
			0	509,046			
<b>D - Depreciation Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,967,692	9		1.00
2.00	OPERATION OF PLANT	7.00	0	43,480	0		2.00
3.00	HOUSEKEEPING	9.00	0	12,616	0		3.00
4.00	DIETARY	10.00	0	77,773	0		4.00
5.00	SOCIAL SERVICE	17.00	0	1,805	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	500,488	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	206,629	0		7.00
8.00	OPERATING ROOM	50.00	0	1,184,295	0		8.00
9.00	RECOVERY ROOM	51.00	0	49,587	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	367,706	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	29,705	0		11.00
12.00	CT SCAN	57.00	0	292,612	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	140,599	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	945,449	0		14.00
15.00	LABORATORY	60.00	0	2,173	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	114,921	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	129,988	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	96,951	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	55,031	0		19.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35,773	0		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	33,708	0		21.00
22.00	ENDOSCOPY	76.00	0	349,230	0		22.00
23.00	IMAGING CENTER	76.06	0	274,737	0		23.00

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-6

Date/Time Prepared:  
5/30/2018 10:44 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
24.00	CARDIAC REHABILITATION	76.97	0	5,928	0		24.00
25.00	ANTI-COAGULATION CLINIC	90.02	0	16,920	0		25.00
26.00	SPI NE CENTER	90.04	0	11,839	0		26.00
27.00	EMERGENCY	91.00	0	92,651	0		27.00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,792	0		28.00
29.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	6,131	0		29.00
	TOTALS		0	9,072,209			
<b>E - Interest Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,582,565	11		1.00
	TOTALS		0	3,582,565			
<b>F - Other Capital Rental</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	71	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	68,875	0		2.00
3.00	HOUSEKEEPING	9.00	0	4,814	0		3.00
4.00	DIETARY	10.00	0	329	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	73	0		5.00
6.00	SOCIAL SERVICE	17.00	0	471	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	45,125	0		7.00
8.00	OPERATING ROOM	50.00	0	62,703	0		8.00
9.00	RECOVERY ROOM	51.00	0	4,410	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	390	0		10.00
11.00	CT SCAN	57.00	0	263	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	1,953	0		12.00
13.00	LABORATORY	60.00	0	80	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	10,022	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	266,618	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	560	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	79,459	0		17.00
18.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	931,127	0		18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	283,402	0		19.00
20.00	RENAL DIALYSIS	74.00	0	48	0		20.00
21.00	ENDOSCOPY	76.00	0	733	0		21.00
22.00	IMAGING CENTER	76.06	0	187,591	0		22.00
23.00	SPI NE CENTER	90.04	0	18,794	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,115	0		24.00
25.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,622	0		25.00
26.00	OPERATION OF PLANT	7.00	0	6,732	0		26.00
	TOTALS		0	2,004,380			
<b>G - STD BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	4,365	0	0		1.00
2.00	OPERATION OF PLANT	7.00	2,304	0	0		2.00
3.00	HOUSEKEEPING	9.00	4,793	0	0		3.00
4.00	DIETARY	10.00	9,392	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	209	0	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	4,817	0	0		6.00
7.00	SOCIAL SERVICE	17.00	4,044	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	171,126	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	18,487	0	0		9.00
10.00	OPERATING ROOM	50.00	22,095	0	0		10.00
11.00	RECOVERY ROOM	51.00	20,796	0	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	5,278	0	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	2,659	0	0		13.00
14.00	CT SCAN	57.00	339	0	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	177	0	0		15.00
16.00	RESPIRATORY THERAPY	65.00	10,734	0	0		16.00
17.00	PHYSICAL THERAPY	66.00	5,551	0	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	6,631	0	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	5,253	0	0		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	16,013	0	0		20.00
21.00	ENDOSCOPY	76.00	1,764	0	0		21.00
22.00	IMAGING CENTER	76.06	2,122	0	0		22.00
23.00	CARDIAC REHABILITATION	76.97	2,572	0	0		23.00
24.00	ANTI-COAGULATION CLINIC	90.02	197	0	0		24.00
25.00	EMERGENCY	91.00	25,242	0	0		25.00
26.00	MISC NONREIMBURSABLE COST CENTERS	194.08	5,909	0	0		26.00
	TOTALS		352,869	0			
<b>H - Labor and Delivery</b>							
1.00	ADULTS & PEDIATRICS	30.00	2,409,465	1,101,160			1.00
2.00							2.00
			2,409,465	1,101,160			

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-6

Date/Time Prepared:  
5/30/2018 10:44 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>I - Cafeteria</b>							
1.00	DIETARY	10.00	817,264	534,297	0		1.00
	TOTALS		817,264	534,297			
<b>J - Therapy</b>							
1.00	PHYSICAL THERAPY	66.00	573,413	181,783			1.00
2.00			573,413	181,783			2.00
<b>K - BUILDING DEPRECIATION</b>							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,887,870	9		1.00
	TOTALS		0	4,887,870			
<b>L - Capital Insurance Costs</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	230,101	12		1.00
	TOTALS		0	230,101			
<b>M - RADIOLOGY SUPPORT STAFF</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	252,160	145,390			1.00
2.00							2.00
3.00			252,160	145,390			3.00
500.00	Grand Total: Decreases		4,405,171	43,542,404			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	497,000	0	0	0	1.00
2.00	Land Improvements	2,722,362	0	0	0	2.00
3.00	Buildings and Fixtures	170,119,449	4,473,839	0	4,473,839	3.00
4.00	Building Improvements	2,826,361	0	0	0	4.00
5.00	Fixed Equipment	880,245	-880,245	0	-880,245	5.00
6.00	Movable Equipment	66,845,902	4,824,210	0	4,824,210	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	243,891,319	8,417,804	0	8,417,804	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	243,891,319	8,417,804	0	8,417,804	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	497,000	0			1.00
2.00	Land Improvements	2,722,362	0			2.00
3.00	Buildings and Fixtures	174,593,288	0			3.00
4.00	Building Improvements	1,547,190	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	71,670,112	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	251,029,952	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	251,029,952	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2018 10:44 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	179,359,840	0	179,359,840	0.714496	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	71,670,112	0	71,670,112	0.285504	0	2.00
3.00	Total (sum of lines 1-2)	251,029,952	0	251,029,952	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,887,870	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,575,347	1,999,330	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,463,217	1,999,330	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,210,915	230,101	0	0	7,328,886	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,574,677	2.00
3.00	Total (sum of lines 1-2)	2,210,915	230,101	0	0	16,903,563	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-8

Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-9,829		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	9	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-155,933				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	1,485,539				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 and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MISC REVENUE	B	-10,288		CARDIAC REHABILITATION	76.97	0	33.00



ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-8

Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.01 MISC REVENUE	B	-107,153	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 MISC REVENUE	B	-15,195	OPERATION OF PLANT	7.00	0 33.02
33.03 MISC REVENUE	B	-10,551	DIETARY	10.00	0 33.03
33.04 MISC REVENUE	B	-90	ADULTS & PEDIATRICS	30.00	0 33.04
33.05 MISC REVENUE	B	-428,783	RADIOLOGY-DIAGNOSTIC	54.00	0 33.05
33.06 MISC REVENUE	B	-12,939	CARDIAC CATHETERIZATION	59.00	0 33.06
33.07 MISC REVENUE	B	-791,438	LABORATORY	60.00	0 33.07
33.08 MISC REVENUE	B	-35,027	PHYSICAL THERAPY	66.00	0 33.08
33.09 MISC REVENUE	B	-8,254	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 33.09
34.00 HAF Tax Offset	A	-9,785,949	ADMINISTRATIVE & GENERAL	5.00	0 34.00
34.01 LOC Non-Allow Interest Expense	A	-45,008	CAP REL COSTS-BLDG & FIXT	1.00	11 34.01
34.02 Non-Allowable Interest Expense 00	A	-900,081	CAP REL COSTS-BLDG & FIXT	1.00	11 34.02
34.03 2012B Non-Allow Interest Expense	A	-68,904	CAP REL COSTS-BLDG & FIXT	1.00	11 34.03
34.04 50M BMO Non-Allow Interest Expense	A	-75,050	CAP REL COSTS-BLDG & FIXT	1.00	11 34.04
34.05 12B Non-Allow Interest Expense	A	-282,607	CAP REL COSTS-BLDG & FIXT	1.00	11 34.05
34.06 50 BMO Loan Non-Allow Interest Expense	A	28,959	ADMINISTRATIVE & GENERAL	5.00	0 34.06
36.00 Meals of Wheels Cost	A	-102,443	CAFETERIA	11.00	0 36.00
36.01 Non Allow Sponsorship	A	-11,670	ADMINISTRATIVE & GENERAL	5.00	0 36.01
36.02 Nurse Practitioner Offset	A	-313,943	ANTI-COAGULATION CLINIC	90.02	0 36.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,656,637			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 15-0128  
 Period: From 01/01/2017 To 12/31/2017  
 Worksheet A-8-1  
 Date/Time Prepared: 5/30/2018 10:44 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	5.00	ADMINISTRATIVE & GENERAL	1550 CTY LN RD	88,533	67,057	1.00
2.00	30.00	ADULTS & PEDIATRICS	1550 CTY LN RD	52,045	39,420	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	3,391,008	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHNW - HOME OFFICE	2,201,853	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	28,982,234	41,254,969	3.02
3.03	7.00	OPERATION OF PLANT	CHNW - HOME OFFICE	577,793	0	3.03
3.04	13.00	NURSING ADMINISTRATION	CHNW - HOME OFFICE	2,196,337	0	3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	CHNW - HOME OFFICE	1,532,560	0	3.05
3.06	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	480,856	0	3.06
3.07	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	203,393	0	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	CHNW - HOME OFFICE	76,140	0	3.08
3.09	69.00	ELECTROCARDIOLOGY	CHNW - HOME OFFICE	125,802	0	3.09
3.10	70.00	ELECTROENCEPHALOGRAPHY	CHNW - HOME OFFICE	100,444	0	3.10
3.11	71.00	MEDICAL SUPPLIES CHARGED TO	CHNW - HOME OFFICE	1,024,992	0	3.11
3.12	73.00	DRUGS CHARGED TO PATIENTS	CHNW - HOME OFFICE	338,273	0	3.12
4.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	524,946	0	4.00
4.01	22.00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	949,776	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			42,846,985	41,361,446	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00	C	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER		0.00	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-8-1

Date/Time Prepared:  
5/30/2018 10:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	21,476	0		1.00
2.00	12,625	0		2.00
3.00	3,391,008	9		3.00
3.01	2,201,853	0		3.01
3.02	-12,272,735	0		3.02
3.03	577,793	0		3.03
3.04	2,196,337	0		3.04
3.05	1,532,560	0		3.05
3.06	480,856	0		3.06
3.07	203,393	0		3.07
3.08	76,140	0		3.08
3.09	125,802	0		3.09
3.10	100,444	0		3.10
3.11	1,024,992	0		3.11
3.12	338,273	0		3.12
4.00	524,946	0		4.00
4.01	949,776	0		4.01
5.00	1,485,539			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet A-8-2

Date/Time Prepared:  
5/30/2018 10:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	341,951	27,881	314,070	211,500	1,972	1.00
2.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	14,500	14,500	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			356,451	42,381	314,070		1,972	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	200,518	10,026	0	0	0	1.00
2.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			200,518	10,026	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	200,518	113,552	141,433	1.00
2.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	14,500	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	200,518	113,552	155,933	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,328,886	7,328,886			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	9,574,677		9,574,677		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,700,259	0	76	2,700,335	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	36,599,678	1,030,504	3,151,317	199,013	40,980,512
7.00 00700	OPERATION OF PLANT	5,334,041	973,502	22,248	69,610	6,399,401
8.00 00800	LAUNDRY & LINEN SERVICE	636,440	20,365	0	0	656,805
9.00 00900	HOUSEKEEPING	2,161,317	44,710	18,636	61,920	2,286,583
10.00 01000	DIETARY	630,001	78,126	26,694	17,457	752,278
11.00 01100	CAFETERIA	1,249,118	164,842	56,414	37,749	1,508,123
13.00 01300	NURSING ADMINISTRATION	2,515,790	0	0	11,929	2,527,719
16.00 01600	MEDICAL RECORDS & LIBRARY	1,838,613	0	78	10,702	1,849,393
17.00 01700	SOCIAL SERVICE	1,561,908	20,457	2,433	54,769	1,639,567
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	524,946	0	0	0	524,946
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	949,776	0	0	0	949,776
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	25,947,014	1,912,513	333,139	841,927	29,034,593
31.00 03100	INTENSIVE CARE UNIT	3,406,469	561,378	220,920	116,840	4,305,607
43.00 04300	NURSERY	966,385	71,184	20,968	30,636	1,089,173
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,983,338	641,133	736,775	140,813	7,502,059
51.00 05100	RECOVERY ROOM	3,617,593	158,307	57,732	118,029	3,951,661
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,214,343	187,410	55,205	107,660	3,564,618
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,238,767	227,954	362,779	66,652	2,896,152
55.00 05500	RADIOLOGY-THERAPEUTIC	702,752	0	32,175	28,591	763,518
57.00 05700	CT SCAN	1,247,588	28,029	294,006	32,109	1,601,732
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	607,235	32,639	129,209	11,440	780,523
59.00 05900	CARDIAC CATHETERIZATION	1,934,138	205,497	767,932	57,682	2,965,249
60.00 06000	LABORATORY	5,467,752	95,899	86	0	5,563,737
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,244,456	47,857	131,465	78,143	2,501,921
66.00 06600	PHYSICAL THERAPY	1,886,233	15,810	523,815	67,163	2,493,021
67.00 06700	OCCUPATIONAL THERAPY	596,660	4,906	30,969	20,926	653,461
68.00 06800	SPEECH PATHOLOGY	158,536	1,296	8,229	5,560	173,621
69.00 06900	ELECTROCARDIOLOGY	1,257,272	115,578	74,051	36,735	1,483,636
70.00 07000	ELECTROENCEPHALOGRAPHY	723,588	46,616	143,792	17,931	931,927
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,737,323	0	1,033,748	0	12,771,071
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	10,365,142	0	0	0	10,365,142
73.00 07300	DRUGS CHARGED TO PATIENTS	11,905,259	27,196	330,255	116,046	12,378,756
74.00 07400	RENAL DIALYSIS	467,664	22,586	51	0	490,301
76.00 03950	ENDOSCOPY	1,341,848	0	330,440	28,575	1,700,863
76.06 03330	IMAGING CENTER	1,560,158	0	494,304	33,533	2,087,995
76.97 07697	CARDIAC REHABILITATION	256,639	0	6,338	9,048	272,025
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02 04951	ANTI-COAGULATION CLINIC	353,409	0	3,975	23,707	381,091
90.03 04952	PALLIATIVE CARE	0	0	0	0	0
90.04 04953	SPINE CENTER	212,354	0	32,661	6,672	251,687
91.00 09100	EMERGENCY	7,303,912	558,083	75,837	222,148	8,159,980
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	181,309,277	7,294,377	9,508,752	2,681,715	181,190,223
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	140,998	0	54,428	21	195,447
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	517,610	34,509	11,497	18,599	582,215
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	181,967,885	7,328,886	9,574,677	2,700,335	181,967,885

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	40,980,512				5.00
7.00	00700	OPERATION OF PLANT	1,860,101	8,259,502			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190,912	31,588	879,305		8.00
9.00	00900	HOUSEKEEPING	664,637	69,350	0	3,020,570	9.00
10.00	01000	DIETARY	218,663	121,182	0	44,866	1,136,989
11.00	01100	CAFETERIA	438,363	255,689	0	94,665	0
13.00	01300	NURSING ADMINISTRATION	734,727	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	537,559	0	0	0	0
17.00	01700	SOCIAL SERVICE	476,570	31,731	0	11,748	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	152,585	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	276,069	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,439,426	2,966,531	395,088	1,098,306	1,045,209
31.00	03100	INTENSIVE CARE UNIT	1,251,502	870,762	45,121	322,385	91,780
43.00	04300	NURSERY	316,588	110,414	18,830	40,879	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,180,608	994,471	90,568	368,186	0
51.00	05100	RECOVERY ROOM	1,148,621	245,552	0	90,912	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,036,120	290,694	49,571	107,625	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	841,819	353,583	14,140	130,908	0
55.00	05500	RADIOLOGY-THERAPEUTIC	221,930	0	12,034	0	0
57.00	05700	CT SCAN	465,572	43,476	0	16,096	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	226,873	50,627	51,164	18,744	0
59.00	05900	CARDIAC CATHETERIZATION	861,903	318,750	0	118,012	0
60.00	06000	LABORATORY	1,617,200	148,750	0	55,072	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	727,228	74,231	0	27,483	0
66.00	06600	PHYSICAL THERAPY	724,641	24,524	0	9,079	0
67.00	06700	OCCUPATIONAL THERAPY	189,940	7,610	0	2,817	0
68.00	06800	SPEECH PATHOLOGY	50,466	2,010	0	744	0
69.00	06900	ELECTROCARDIOLOGY	431,246	179,275	0	66,374	0
70.00	07000	ELECTROENCEPHALOGRAPHY	270,881	72,307	0	26,771	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,712,142	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,012,815	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,598,108	42,184	0	15,618	0
74.00	07400	RENAL DIALYSIS	142,515	35,034	0	12,971	0
76.00	03950	ENDOSCOPY	494,386	0	0	0	0
76.06	03330	IMAGING CENTER	606,913	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	79,069	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	110,771	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	73,157	0	0	0	0
91.00	09100	EMERGENCY	2,371,845	865,650	202,789	320,492	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,754,471	8,205,975	879,305	3,000,753	1,136,989
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,810	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	169,231	53,527	0	19,817	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	40,980,512	8,259,502	879,305	3,020,570	1,136,989

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period: From 01/01/2017 To 12/31/2017

Worksheet B Part I Date/Time Prepared: 5/30/2018 10:44 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES		
	11.00	13.00	16.00	17.00	21.00		
<b>GENERAL SERVICE COST CENTERS</b>							
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	2,296,840					11.00	
13.00 01300 NURSING ADMINISTRATION	27,798	3,290,244				13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	10,424		2,397,376			16.00	
17.00 01700 SOCIAL SERVICE	52,122			2,211,738		17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	677,531	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	917,346	2,341,306	291,180	1,877,179	517,265	30.00	
31.00 03100 INTENSIVE CARE UNIT	93,819	239,452	26,547	154,819	47,984	31.00	
43.00 04300 NURSERY	31,273	79,817	11,691	179,740	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	159,841	0	280,037	0	16,314	50.00	
51.00 05100 RECOVERY ROOM	104,244	0	93,767	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	79,920	0	29,557	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	76,446	0	85,579	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	27,798	0	55,429	0	0	55.00	
57.00 05700 CT SCAN	38,223	0	146,303	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10,424	0	28,917	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	55,597	0	165,661	0	0	59.00	
60.00 06000 LABORATORY	0	0	207,052	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	83,395	0	38,198	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	34,748	0	23,924	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	20,849	0	7,791	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	6,950	0	2,070	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	59,072	0	63,825	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	17,374	0	13,225	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	132,856	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	101,462	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	100,769	0	171,785	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	4,340	0	0	74.00	
76.00 03950 ENDOSCOPY	24,324	0	29,914	0	0	76.00	
76.06 03330 IMAGING CENTER	3,475	0	36,364	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	13,899	0	4,033	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	0	4,137	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	0	1,158	0	0	90.04	
91.00 09100 EMERGENCY	246,710	629,669	340,574	0	71,976	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,296,840	3,290,244	2,397,376	2,211,738	653,539	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	23,992	194.08	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,296,840	3,290,244	2,397,376	2,211,738	677,531	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SERVICES-OTHER PRGM. COSTS					
	22.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
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	
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00 01700	SOCIAL SERVICE				17.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00	
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,225,845			22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	935,879	49,859,308	-1,453,144	48,406,164	30.00
31.00 03100	INTENSIVE CARE UNIT	86,816	7,536,594	-134,800	7,401,794	31.00
43.00 04300	NURSERY	0	1,878,405	0	1,878,405	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	29,518	11,621,602	-45,832	11,575,770	50.00
51.00 05100	RECOVERY ROOM	0	5,634,757	0	5,634,757	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	5,158,105	0	5,158,105	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	4,398,627	0	4,398,627	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,080,709	0	1,080,709	55.00
57.00 05700	CT SCAN	0	2,311,402	0	2,311,402	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,167,272	0	1,167,272	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	4,485,172	0	4,485,172	59.00
60.00 06000	LABORATORY	0	7,591,811	0	7,591,811	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	3,452,456	0	3,452,456	65.00
66.00 06600	PHYSICAL THERAPY	0	3,309,937	0	3,309,937	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	882,468	0	882,468	67.00
68.00 06800	SPEECH PATHOLOGY	0	235,861	0	235,861	68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,283,428	0	2,283,428	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	1,332,485	0	1,332,485	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,616,069	0	16,616,069	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,479,419	0	13,479,419	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	16,307,220	0	16,307,220	73.00
74.00 07400	RENAL DIALYSIS	0	685,161	0	685,161	74.00
76.00 03950	ENDOSCOPY	0	2,249,487	0	2,249,487	76.00
76.06 03330	IMAGING CENTER	0	2,734,747	0	2,734,747	76.06
76.97 07697	CARDIAC REHABILITATION	0	369,026	0	369,026	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	495,999	0	495,999	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	326,002	0	326,002	90.04
91.00 09100	EMERGENCY	130,224	13,339,909	-202,200	13,137,709	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,182,437	180,823,438	-1,835,976	178,987,462	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	252,257	0	252,257	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	43,408	892,190	-67,400	824,790	194.08
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,225,845	181,967,885	-1,903,376	180,064,509	202.00



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	0	76	76	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,030,504	3,151,317	4,181,821	5.00
7.00 00700	OPERATION OF PLANT	0	973,502	22,248	995,750	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	20,365	0	20,365	8.00
9.00 00900	HOUSEKEEPING	0	44,710	18,636	63,346	9.00
10.00 01000	DIETARY	0	78,126	26,694	104,820	10.00
11.00 01100	CAFETERIA	0	164,842	56,414	221,256	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	78	78	16.00
17.00 01700	SOCIAL SERVICE	0	20,457	2,433	22,890	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,912,513	333,139	2,245,652	30.00
31.00 03100	INTENSIVE CARE UNIT	0	561,378	220,920	782,298	31.00
43.00 04300	NURSERY	0	71,184	20,968	92,152	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	641,133	736,775	1,377,908	50.00
51.00 05100	RECOVERY ROOM	0	158,307	57,732	216,039	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	187,410	55,205	242,615	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	227,954	362,779	590,733	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	32,175	32,175	55.00
57.00 05700	CT SCAN	0	28,029	294,006	322,035	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	32,639	129,209	161,848	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	205,497	767,932	973,429	59.00
60.00 06000	LABORATORY	0	95,899	86	95,985	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	47,857	131,465	179,322	65.00
66.00 06600	PHYSICAL THERAPY	0	15,810	523,815	539,625	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,906	30,969	35,875	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,296	8,229	9,525	68.00
69.00 06900	ELECTROCARDIOLOGY	0	115,578	74,051	189,629	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	46,616	143,792	190,408	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,033,748	1,033,748	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	27,196	330,255	357,451	73.00
74.00 07400	RENAL DIALYSIS	0	22,586	51	22,637	74.00
76.00 03950	ENDOSCOPY	0	0	330,440	330,440	76.00
76.06 03330	IMAGING CENTER	0	0	494,304	494,304	76.06
76.97 07697	CARDIAC REHABILITATION	0	0	6,338	6,338	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	0	3,975	3,975	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	0	32,661	32,661	90.04
91.00 09100	EMERGENCY	0	558,083	75,837	633,920	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,294,377	9,508,752	16,803,129	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	54,428	54,428	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	0	34,509	11,497	46,006	194.08
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	7,328,886	9,574,677	16,903,563	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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	4,181,825					5.00
7.00	00700	OPERATION OF PLANT	189,813	1,185,565				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,481	4,534	44,380			8.00
9.00	00900	HOUSEKEEPING	67,822	9,954	0	141,123		9.00
10.00	01000	DIETARY	22,313	17,394	0	2,096	146,623	10.00
11.00	01100	CAFETERIA	44,732	36,702	0	4,423	0	11.00
13.00	01300	NURSING ADMINISTRATION	74,975	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,855	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	48,631	4,555	0	549	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	15,570	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	28,171	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	861,196	425,814	19,942	51,312	134,787	30.00
31.00	03100	INTENSIVE CARE UNIT	127,709	124,989	2,277	15,062	11,836	31.00
43.00	04300	NURSERY	32,306	15,849	950	1,910	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	222,519	142,746	4,571	17,202	0	50.00
51.00	05100	RECOVERY ROOM	117,210	35,246	0	4,247	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,730	41,726	2,502	5,028	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,903	50,753	714	6,116	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	22,647	0	607	0	0	55.00
57.00	05700	CT SCAN	47,509	6,241	0	752	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,151	7,267	2,582	876	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	87,952	45,753	0	5,514	0	59.00
60.00	06000	LABORATORY	165,026	21,352	0	2,573	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	74,209	10,655	0	1,284	0	65.00
66.00	06600	PHYSICAL THERAPY	73,945	3,520	0	424	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,382	1,092	0	132	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,150	289	0	35	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44,006	25,733	0	3,101	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,642	10,379	0	1,251	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	378,803	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	307,440	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,166	6,055	0	730	0	73.00
74.00	07400	RENAL DIALYSIS	14,543	5,029	0	606	0	74.00
76.00	03950	ENDOSCOPY	50,449	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	61,932	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	8,069	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	11,304	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	7,465	0	0	0	0	90.04
91.00	09100	EMERGENCY	242,033	124,255	10,235	14,974	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,158,759	1,177,882	44,380	140,197	146,623	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,797	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	17,269	7,683	0	926	0	194.08
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,181,825	1,185,565	44,380	141,123	146,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 10:44 am		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES
		11.00	13.00	16.00	17.00	21.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	307,114				11.00
13.00	01300	3,717	78,692			13.00
16.00	01600	1,394	0	56,327		16.00
17.00	01700	6,969	0	0	83,595	17.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	122,658	55,996	6,840	70,950	30.00
31.00	03100	12,545	5,727	624	5,852	31.00
43.00	04300	4,182	1,909	275	6,793	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	21,373	0	6,578	0	50.00
51.00	05100	13,939	0	2,203	0	51.00
52.00	05200	10,686	0	694	0	52.00
54.00	05400	10,222	0	2,010	0	54.00
55.00	05500	3,717	0	1,302	0	55.00
57.00	05700	5,111	0	3,437	0	57.00
58.00	05800	1,394	0	679	0	58.00
59.00	05900	7,434	0	3,892	0	59.00
60.00	06000	0	0	4,864	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	11,151	0	897	0	65.00
66.00	06600	4,646	0	562	0	66.00
67.00	06700	2,788	0	183	0	67.00
68.00	06800	929	0	49	0	68.00
69.00	06900	7,899	0	1,499	0	69.00
70.00	07000	2,323	0	311	0	70.00
71.00	07100	0	0	3,121	0	71.00
72.00	07200	0	0	2,383	0	72.00
73.00	07300	13,474	0	4,035	0	73.00
74.00	07400	0	0	102	0	74.00
76.00	03950	3,252	0	703	0	76.00
76.06	03330	465	0	854	0	76.06
76.97	07697	1,858	0	95	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
90.01	04950	0	0	0	0	90.01
90.02	04951	0	0	97	0	90.02
90.03	04952	0	0	0	0	90.03
90.04	04953	0	0	27	0	90.04
91.00	09100	32,988	15,060	8,011	0	91.00
92.00	09200					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		307,114	78,692	56,327	83,595	0
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
200.00						15,570
201.00		0	0	0	0	0
202.00		307,114	78,692	56,327	83,595	15,570

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 10:44 am
Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM. COSTS				
	22.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	28,171		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	3,995,183	0	3,995,183
31.00	03100	INTENSIVE CARE UNIT	1,088,922	0	1,088,922
43.00	04300	NURSERY	156,327	0	156,327
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1,792,900	0	1,792,900
51.00	05100	RECOVERY ROOM	388,887	0	388,887
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,983	0	408,983
54.00	05400	RADIOLOGY-DIAGNOSTIC	746,452	0	746,452
55.00	05500	RADIOLOGY-THERAPEUTIC	60,449	0	60,449
57.00	05700	CT SCAN	385,086	0	385,086
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,797	0	197,797
59.00	05900	CARDIAC CATHETERIZATION	1,123,975	0	1,123,975
60.00	06000	LABORATORY	289,800	0	289,800
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	277,520	0	277,520
66.00	06600	PHYSICAL THERAPY	622,723	0	622,723
67.00	06700	OCCUPATIONAL THERAPY	59,452	0	59,452
68.00	06800	SPEECH PATHOLOGY	15,977	0	15,977
69.00	06900	ELECTROCARDIOLOGY	271,868	0	271,868
70.00	07000	ELECTROENCEPHALOGRAPHY	232,314	0	232,314
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,415,672	0	1,415,672
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	309,823	0	309,823
73.00	07300	DRUGS CHARGED TO PATIENTS	748,914	0	748,914
74.00	07400	RENAL DIALYSIS	42,917	0	42,917
76.00	03950	ENDOSCOPY	384,845	0	384,845
76.06	03330	IMAGING CENTER	557,556	0	557,556
76.97	07697	CARDIAC REHABILITATION	16,360	0	16,360
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	15,377	0	15,377
90.03	04952	PALLIATIVE CARE	0	0	0
90.04	04953	SPINE CENTER	40,153	0	40,153
91.00	09100	EMERGENCY	1,081,481	0	1,081,481
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,727,713	16,727,713
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,225	0	60,225
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	HOME OFFICE	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	71,884	0	71,884
200.00		Cross Foot Adjustments	28,171	43,741	43,741
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	28,171	16,903,563	16,903,563

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	395,872					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		8,955,301				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	71	58,461,216			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	55,663	2,947,460	4,308,582	-40,980,512	140,987,373	5.00
7.00 00700	OPERATION OF PLANT	52,584	20,809	1,507,038	0	6,399,401	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,100	0	0	0	656,805	8.00
9.00 00900	HOUSEKEEPING	2,415	17,430	1,340,551	0	2,286,583	9.00
10.00 01000	DIETARY	4,220	24,967	377,939	0	752,278	10.00
11.00 01100	CAFETERIA	8,904	52,765	817,264	0	1,508,123	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	258,261	0	2,527,719	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	73	231,700	0	1,849,393	16.00
17.00 01700	SOCIAL SERVICE	1,105	2,276	1,185,731	0	1,639,567	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	524,946	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	949,776	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	103,305	311,589	18,227,238	0	29,034,593	30.00
31.00 03100	INTENSIVE CARE UNIT	30,323	206,629	2,529,554	0	4,305,607	31.00
43.00 04300	NURSERY	3,845	19,612	663,264	0	1,089,173	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	34,631	689,114	3,048,554	0	7,502,059	50.00
51.00 05100	RECOVERY ROOM	8,551	53,997	2,555,284	0	3,951,661	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,123	51,634	2,330,801	0	3,564,618	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,313	339,311	1,442,998	0	2,896,152	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	30,094	618,976	0	763,518	55.00
57.00 05700	CT SCAN	1,514	274,987	695,149	0	1,601,732	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,763	120,851	247,665	0	780,523	58.00
59.00 05900	CARDIAC CATHETERIZATION	11,100	718,255	1,248,793	0	2,965,249	59.00
60.00 06000	LABORATORY	5,180	80	0	0	5,563,737	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	2,585	122,961	1,691,776	0	2,501,921	65.00
66.00 06600	PHYSICAL THERAPY	854	489,930	1,454,062	0	2,493,021	66.00
67.00 06700	OCCUPATIONAL THERAPY	265	28,966	453,038	0	653,461	67.00
68.00 06800	SPEECH PATHOLOGY	70	7,697	120,375	0	173,621	68.00
69.00 06900	ELECTROCARDIOLOGY	6,243	69,261	795,305	0	1,483,636	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,518	134,490	388,200	0	931,927	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	966,876	0	0	12,771,071	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,365,142	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,469	308,891	2,512,361	0	12,378,756	73.00
74.00 07400	RENAL DIALYSIS	1,220	48	0	0	490,301	74.00
76.00 03950	ENDOSCOPY	0	309,064	618,648	0	1,700,863	76.00
76.06 03330	IMAGING CENTER	0	462,328	725,989	0	2,087,995	76.06
76.97 07697	CARDIAC REHABILITATION	0	5,928	195,880	0	272,025	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	3,718	513,240	0	381,091	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	30,548	144,446	0	251,687	90.04
91.00 09100	EMERGENCY	30,145	70,931	4,809,438	0	8,159,980	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	394,008	8,893,641	58,058,100	-40,980,512	140,209,711	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	50,907	455	0	195,447	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	1,864	10,753	402,661	0	582,215	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7,328,886	9,574,677	2,700,335		40,980,512	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.513272	1.069163	0.046190		0.290668	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			76		4,181,825	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000001		0.029661	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet B-1

Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	287,625				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,100	150,739			8.00
9.00	00900	HOUSEKEEPING	2,415	0	284,110		9.00
10.00	01000	DIETARY	4,220	0	4,220	34,402	10.00
11.00	01100	CAFETERIA	8,904	0	8,904	0	661
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	8
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	3
17.00	01700	SOCIAL SERVICE	1,105	0	1,105	0	15
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	103,305	67,730	103,305	31,625	264
31.00	03100	INTENSIVE CARE UNIT	30,323	7,735	30,323	2,777	27
43.00	04300	NURSERY	3,845	3,228	3,845	0	9
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	34,631	15,526	34,631	0	46
51.00	05100	RECOVERY ROOM	8,551	0	8,551	0	30
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,123	8,498	10,123	0	23
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,313	2,424	12,313	0	22
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,063	0	0	8
57.00	05700	CT SCAN	1,514	0	1,514	0	11
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,763	8,771	1,763	0	3
59.00	05900	CARDIAC CATHETERIZATION	11,100	0	11,100	0	16
60.00	06000	LABORATORY	5,180	0	5,180	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,585	0	2,585	0	24
66.00	06600	PHYSICAL THERAPY	854	0	854	0	10
67.00	06700	OCCUPATIONAL THERAPY	265	0	265	0	6
68.00	06800	SPEECH PATHOLOGY	70	0	70	0	2
69.00	06900	ELECTROCARDIOLOGY	6,243	0	6,243	0	17
70.00	07000	ELECTROENCEPHALOGRAPHY	2,518	0	2,518	0	5
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,469	0	1,469	0	29
74.00	07400	RENAL DIALYSIS	1,220	0	1,220	0	0
76.00	03950	ENDOSCOPY	0	0	0	0	7
76.06	03330	IMAGING CENTER	0	0	0	0	1
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	4
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	30,145	34,764	30,145	0	71
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285,761	150,739	282,246	34,402	661
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	1,864	0	1,864	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	8,259,502	879,305	3,020,570	1,136,989	2,296,840
203.00		Unit cost multiplier (Wkst. B, Part I)	28.716217	5.833295	10.631692	33.050084	3,474.795764
204.00		Cost to be allocated (per Wkst. B, Part II)	1,185,565	44,380	141,123	146,623	307,114
205.00		Unit cost multiplier (Wkst. B, Part II)	4.121912	0.294416	0.496720	4.262049	464.620272
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0128			Period: From 01/01/2017 To 12/31/2017		Worksheet B-1 Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)		
		7.00	8.00	9.00	10.00	11.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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5/30/2018 10:44 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
<b>GENERAL SERVICE COST CENTERS</b>							
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	371					13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	866,556,742				16.00	
17.00 01700 SOCIAL SERVICE	0	0	39,672			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	706		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	706	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	264	105,233,067	33,671	539	539	30.00	
31.00 03100 INTENSIVE CARE UNIT	27	9,594,047	2,777	50	50	31.00	
43.00 04300 NURSERY	9	4,225,045	3,224	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	101,205,888	0	17	17	50.00	
51.00 05100 RECOVERY ROOM	0	33,887,621	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	10,681,902	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	30,928,399	0	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	20,032,118	0	0	0	55.00	
57.00 05700 CT SCAN	0	52,874,382	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,450,632	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	59,870,418	0	0	0	59.00	
60.00 06000 LABORATORY	0	74,829,151	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	13,804,881	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	8,646,035	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	2,815,569	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	748,071	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	23,066,507	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	4,779,422	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48,014,495	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	36,668,548	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	62,083,343	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	1,568,615	0	0	0	74.00	
76.00 03950 ENDOSCOPY	0	10,810,889	0	0	0	76.00	
76.06 03330 IMAGING CENTER	0	13,142,063	0	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	0	1,457,627	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	1,495,061	0	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	418,581	0	0	0	90.04	
91.00 09100 EMERGENCY	71	123,224,365	0	75	75	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	371	866,556,742	39,672	681	681	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	25	25	194.08	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3,290,244	2,397,376	2,211,738	677,531	1,225,845	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8,868.582210	0.002767	55.750605	959.675637	1,736.324363	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,692	56,327	83,595	15,570	28,171	204.00

COST ALLOCATION - STATISTICAL BASIS

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Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description	NURSING ADMINISTRATION  (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
205.00	Unit cost multiplier (Wkst. B, Part II)	212.107817	0.000065	2.107154	22.053824	39.902266	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	48,406,164		48,406,164	0	48,406,164	30.00
31.00	03100 INTENSIVE CARE UNIT	7,401,794		7,401,794	0	7,401,794	31.00
43.00	04300 NURSERY	1,878,405		1,878,405	0	1,878,405	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,575,770		11,575,770	0	11,575,770	50.00
51.00	05100 RECOVERY ROOM	5,634,757		5,634,757	0	5,634,757	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,158,105		5,158,105	0	5,158,105	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,398,627		4,398,627	0	4,398,627	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,080,709		1,080,709	0	1,080,709	55.00
57.00	05700 CT SCAN	2,311,402		2,311,402	0	2,311,402	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,167,272		1,167,272	0	1,167,272	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,485,172		4,485,172	0	4,485,172	59.00
60.00	06000 LABORATORY	7,591,811		7,591,811	0	7,591,811	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,452,456	0	3,452,456	0	3,452,456	65.00
66.00	06600 PHYSICAL THERAPY	3,309,937	0	3,309,937	0	3,309,937	66.00
67.00	06700 OCCUPATIONAL THERAPY	882,468	0	882,468	0	882,468	67.00
68.00	06800 SPEECH PATHOLOGY	235,861	0	235,861	0	235,861	68.00
69.00	06900 ELECTROCARDIOLOGY	2,283,428		2,283,428	0	2,283,428	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,332,485		1,332,485	0	1,332,485	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,616,069		16,616,069	0	16,616,069	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,479,419		13,479,419	0	13,479,419	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,307,220		16,307,220	0	16,307,220	73.00
74.00	07400 RENAL DIALYSIS	685,161		685,161	0	685,161	74.00
76.00	03950 ENDOSCOPY	2,249,487		2,249,487	0	2,249,487	76.00
76.06	03330 IMAGING CENTER	2,734,747		2,734,747	0	2,734,747	76.06
76.97	07697 CARDIAC REHABILITATION	369,026		369,026	0	369,026	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	495,999		495,999	0	495,999	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	326,002		326,002	0	326,002	90.04
91.00	09100 EMERGENCY	13,137,709		13,137,709	0	13,137,709	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,622,582		5,622,582	0	5,622,582	92.00
200.00	Subtotal (see instructions)	184,610,044	0	184,610,044	0	184,610,044	200.00
201.00	Less Observation Beds	5,622,582		5,622,582	0	5,622,582	201.00
202.00	Total (see instructions)	178,987,462	0	178,987,462	0	178,987,462	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	98,723,472		98,723,472	30.00
31.00	03100	INTENSIVE CARE UNIT	9,594,047		9,594,047	31.00
43.00	04300	NURSERY	4,225,045		4,225,045	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	62,172,571	39,033,317	101,205,888	50.00
51.00	05100	RECOVERY ROOM	13,253,779	20,633,842	33,887,621	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,681,902	0	10,681,902	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,794,279	23,134,120	30,928,399	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,259,475	12,772,643	20,032,118	55.00
57.00	05700	CT SCAN	13,587,635	39,286,747	52,874,382	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,468,762	7,981,870	10,450,632	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,503,793	33,366,625	59,870,418	59.00
60.00	06000	LABORATORY	41,861,185	32,967,966	74,829,151	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,240,090	1,564,791	13,804,881	65.00
66.00	06600	PHYSICAL THERAPY	3,248,038	5,397,997	8,646,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,104,074	711,495	2,815,569	67.00
68.00	06800	SPEECH PATHOLOGY	587,464	160,607	748,071	68.00
69.00	06900	ELECTROCARDIOLOGY	7,348,520	15,717,987	23,066,507	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	252,729	4,526,693	4,779,422	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,154,971	18,859,524	48,014,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,750,750	12,917,798	36,668,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,372,703	20,710,640	62,083,343	73.00
74.00	07400	RENAL DIALYSIS	1,568,615	0	1,568,615	74.00
76.00	03950	ENDOSCOPY	2,197,386	8,613,503	10,810,889	76.00
76.06	03330	IMAGING CENTER	119,893	13,022,170	13,142,063	76.06
76.97	07697	CARDIAC REHABILITATION	3,100	1,454,527	1,457,627	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	11,719	1,483,342	1,495,061	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	90.03
90.04	04953	SPINE CENTER	0	418,581	418,581	90.04
91.00	09100	EMERGENCY	24,197,771	99,026,594	123,224,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,260,627	5,248,968	6,509,595	92.00
200.00		Subtotal (see instructions)	447,544,395	419,012,347	866,556,742	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	447,544,395	419,012,347	866,556,742	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.114378		50.00
51.00	05100 RECOVERY ROOM	0.166278		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.482883		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142220		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.053949		55.00
57.00	05700 CT SCAN	0.043715		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.111694		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.074915		59.00
60.00	06000 LABORATORY	0.101455		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.250090		65.00
66.00	06600 PHYSICAL THERAPY	0.382827		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313424		67.00
68.00	06800 SPEECH PATHOLOGY	0.315292		68.00
69.00	06900 ELECTROCARDIOLOGY	0.098993		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278796		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346064		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.367602		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262667		73.00
74.00	07400 RENAL DIALYSIS	0.436794		74.00
76.00	03950 ENDOSCOPY	0.208076		76.00
76.06	03330 IMAGING CENTER	0.208091		76.06
76.97	07697 CARDIAC REHABILITATION	0.253169		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.331758		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	0.778827		90.04
91.00	09100 EMERGENCY	0.106616		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.863738		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	48,406,164		48,406,164	0	48,406,164	30.00
31.00	03100 INTENSIVE CARE UNIT	7,401,794		7,401,794	0	7,401,794	31.00
43.00	04300 NURSERY	1,878,405		1,878,405	0	1,878,405	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,575,770		11,575,770	0	11,575,770	50.00
51.00	05100 RECOVERY ROOM	5,634,757		5,634,757	0	5,634,757	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,158,105		5,158,105	0	5,158,105	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,398,627		4,398,627	0	4,398,627	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,080,709		1,080,709	0	1,080,709	55.00
57.00	05700 CT SCAN	2,311,402		2,311,402	0	2,311,402	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,167,272		1,167,272	0	1,167,272	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,485,172		4,485,172	0	4,485,172	59.00
60.00	06000 LABORATORY	7,591,811		7,591,811	0	7,591,811	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,452,456	0	3,452,456	0	3,452,456	65.00
66.00	06600 PHYSICAL THERAPY	3,309,937	0	3,309,937	0	3,309,937	66.00
67.00	06700 OCCUPATIONAL THERAPY	882,468	0	882,468	0	882,468	67.00
68.00	06800 SPEECH PATHOLOGY	235,861	0	235,861	0	235,861	68.00
69.00	06900 ELECTROCARDIOLOGY	2,283,428		2,283,428	0	2,283,428	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,332,485		1,332,485	0	1,332,485	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,616,069		16,616,069	0	16,616,069	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,479,419		13,479,419	0	13,479,419	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,307,220		16,307,220	0	16,307,220	73.00
74.00	07400 RENAL DIALYSIS	685,161		685,161	0	685,161	74.00
76.00	03950 ENDOSCOPY	2,249,487		2,249,487	0	2,249,487	76.00
76.06	03330 IMAGING CENTER	2,734,747		2,734,747	0	2,734,747	76.06
76.97	07697 CARDIAC REHABILITATION	369,026		369,026	0	369,026	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	495,999		495,999	0	495,999	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	326,002		326,002	0	326,002	90.04
91.00	09100 EMERGENCY	13,137,709		13,137,709	0	13,137,709	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,622,582		5,622,582	0	5,622,582	92.00
200.00	Subtotal (see instructions)	184,610,044	0	184,610,044	0	184,610,044	200.00
201.00	Less Observation Beds	5,622,582		5,622,582	0	5,622,582	201.00
202.00	Total (see instructions)	178,987,462	0	178,987,462	0	178,987,462	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 10:44 am
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		Title XIX			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	98,723,472		98,723,472			30.00
31.00	03100	INTENSIVE CARE UNIT	9,594,047		9,594,047			31.00
43.00	04300	NURSERY	4,225,045		4,225,045			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	62,172,571	39,033,317	101,205,888	0.114378	0.000000	50.00
51.00	05100	RECOVERY ROOM	13,253,779	20,633,842	33,887,621	0.166278	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,681,902	0	10,681,902	0.482883	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,794,279	23,134,120	30,928,399	0.142220	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,259,475	12,772,643	20,032,118	0.053949	0.000000	55.00
57.00	05700	CT SCAN	13,587,635	39,286,747	52,874,382	0.043715	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,468,762	7,981,870	10,450,632	0.111694	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,503,793	33,366,625	59,870,418	0.074915	0.000000	59.00
60.00	06000	LABORATORY	41,861,185	32,967,966	74,829,151	0.101455	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	12,240,090	1,564,791	13,804,881	0.250090	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,248,038	5,397,997	8,646,035	0.382827	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,104,074	711,495	2,815,569	0.313424	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	587,464	160,607	748,071	0.315292	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,348,520	15,717,987	23,066,507	0.098993	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	252,729	4,526,693	4,779,422	0.278796	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,154,971	18,859,524	48,014,495	0.346064	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,750,750	12,917,798	36,668,548	0.367602	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,372,703	20,710,640	62,083,343	0.262667	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,568,615	0	1,568,615	0.436794	0.000000	74.00
76.00	03950	ENDOSCOPY	2,197,386	8,613,503	10,810,889	0.208076	0.000000	76.00
76.06	03330	IMAGING CENTER	119,893	13,022,170	13,142,063	0.208091	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	3,100	1,454,527	1,457,627	0.253169	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	11,719	1,483,342	1,495,061	0.331758	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	418,581	418,581	0.778827	0.000000	90.04
91.00	09100	EMERGENCY	24,197,771	99,026,594	123,224,365	0.106616	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,260,627	5,248,968	6,509,595	0.863738	0.000000	92.00
200.00		Subtotal (see instructions)	447,544,395	419,012,347	866,556,742			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	447,544,395	419,012,347	866,556,742			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 10:44 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.114378		50.00
51.00	05100 RECOVERY ROOM	0.166278		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.482883		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142220		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.053949		55.00
57.00	05700 CT SCAN	0.043715		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.111694		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.074915		59.00
60.00	06000 LABORATORY	0.101455		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.250090		65.00
66.00	06600 PHYSICAL THERAPY	0.382827		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313424		67.00
68.00	06800 SPEECH PATHOLOGY	0.315292		68.00
69.00	06900 ELECTROCARDIOLOGY	0.098993		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278796		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346064		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.367602		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262667		73.00
74.00	07400 RENAL DIALYSIS	0.436794		74.00
76.00	03950 ENDOSCOPY	0.208076		76.00
76.06	03330 IMAGING CENTER	0.208091		76.06
76.97	07697 CARDIAC REHABILITATION	0.253169		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.331758		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	0.778827		90.04
91.00	09100 EMERGENCY	0.106616		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.863738		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00



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

Provider CCN: 15-0128

Period: From 01/01/2017 To 12/31/2017

Worksheet C Part II Date/Time Prepared: 5/30/2018 10:44 am

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	11,575,770	1,792,900	9,782,870	0	0	50.00
51.00	05100	RECOVERY ROOM	5,634,757	388,887	5,245,870	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,158,105	408,983	4,749,122	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,398,627	746,452	3,652,175	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,080,709	60,449	1,020,260	0	0	55.00
57.00	05700	CT SCAN	2,311,402	385,086	1,926,316	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,167,272	197,797	969,475	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,485,172	1,123,975	3,361,197	0	0	59.00
60.00	06000	LABORATORY	7,591,811	289,800	7,302,011	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,452,456	277,520	3,174,936	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,309,937	622,723	2,687,214	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	882,468	59,452	823,016	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	235,861	15,977	219,884	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,283,428	271,868	2,011,560	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332,485	232,314	1,100,171	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,616,069	1,415,672	15,200,397	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,479,419	309,823	13,169,596	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,307,220	748,914	15,558,306	0	0	73.00
74.00	07400	RENAL DIALYSIS	685,161	42,917	642,244	0	0	74.00
76.00	03950	ENDOSCOPY	2,249,487	384,845	1,864,642	0	0	76.00
76.06	03330	IMAGING CENTER	2,734,747	557,556	2,177,191	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	369,026	16,360	352,666	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	495,999	15,377	480,622	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	326,002	40,153	285,849	0	0	90.04
91.00	09100	EMERGENCY	13,137,709	1,081,481	12,056,228	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,622,582	464,060	5,158,522	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	126,923,681	11,951,341	114,972,340	0	0	200.00
201.00		Less Observation Beds	5,622,582	464,060	5,158,522	0	0	201.00
202.00		Total (line 200 minus line 201)	121,301,099	11,487,281	109,813,818	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part II Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XIX			Hospital	PPS
		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	11,575,770	101,205,888	0.114378	50.00
51.00	05100	RECOVERY ROOM	5,634,757	33,887,621	0.166278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,158,105	10,681,902	0.482883	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,398,627	30,928,399	0.142220	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,080,709	20,032,118	0.053949	55.00
57.00	05700	CT SCAN	2,311,402	52,874,382	0.043715	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,167,272	10,450,632	0.111694	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,485,172	59,870,418	0.074915	59.00
60.00	06000	LABORATORY	7,591,811	74,829,151	0.101455	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,452,456	13,804,881	0.250090	65.00
66.00	06600	PHYSICAL THERAPY	3,309,937	8,646,035	0.382827	66.00
67.00	06700	OCCUPATIONAL THERAPY	882,468	2,815,569	0.313424	67.00
68.00	06800	SPEECH PATHOLOGY	235,861	748,071	0.315292	68.00
69.00	06900	ELECTROCARDIOLOGY	2,283,428	23,066,507	0.098993	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332,485	4,779,422	0.278796	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,616,069	48,014,495	0.346064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,479,419	36,668,548	0.367602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,307,220	62,083,343	0.262667	73.00
74.00	07400	RENAL DIALYSIS	685,161	1,568,615	0.436794	74.00
76.00	03950	ENDOSCOPY	2,249,487	10,810,889	0.208076	76.00
76.06	03330	IMAGING CENTER	2,734,747	13,142,063	0.208091	76.06
76.97	07697	CARDIAC REHABILITATION	369,026	1,457,627	0.253169	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	495,999	1,495,061	0.331758	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	90.03
90.04	04953	SPIRE CENTER	326,002	418,581	0.778827	90.04
91.00	09100	EMERGENCY	13,137,709	123,224,365	0.106616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,622,582	6,509,595	0.863738	92.00
200.00		Subtotal (sum of lines 50 thru 199)	126,923,681	754,014,178		200.00
201.00		Less Observation Beds	5,622,582	0		201.00
202.00		Total (line 200 minus line 201)	121,301,099	754,014,178		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/30/2018 10:44 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,995,183	0	3,995,183	38,096	104.87	30.00
31.00	INTENSIVE CARE UNIT	1,088,922		1,088,922	2,777	392.12	31.00
43.00	NURSERY	156,327		156,327	3,224	48.49	43.00
200.00	Total (Lines 30 through 199)	5,240,432		5,240,432	44,097		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	13,325	1,397,393				
31.00	INTENSIVE CARE UNIT	1,043	408,981				
43.00	NURSERY	0	0				
200.00	Total (Lines 30 through 199)	14,368	1,806,374				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,792,900	101,205,888	0.017715	24,458,145	433,276	50.00
51.00	05100	RECOVERY ROOM	388,887	33,887,621	0.011476	4,138,804	47,497	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,983	10,681,902	0.038287	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	746,452	30,928,399	0.024135	3,551,067	85,705	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,449	20,032,118	0.003018	3,396,360	10,250	55.00
57.00	05700	CT SCAN	385,086	52,874,382	0.007283	5,830,590	42,464	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,797	10,450,632	0.018927	990,406	18,745	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,123,975	59,870,418	0.018773	10,412,283	195,470	59.00
60.00	06000	LABORATORY	289,800	74,829,151	0.003873	17,937,167	69,471	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	277,520	13,804,881	0.020103	4,626,985	93,016	65.00
66.00	06600	PHYSICAL THERAPY	622,723	8,646,035	0.072024	1,527,746	110,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,452	2,815,569	0.021115	1,085,266	22,915	67.00
68.00	06800	SPEECH PATHOLOGY	15,977	748,071	0.021358	294,830	6,297	68.00
69.00	06900	ELECTROCARDIOLOGY	271,868	23,066,507	0.011786	3,777,728	44,524	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	232,314	4,779,422	0.048607	114,252	5,553	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,415,672	48,014,495	0.029484	10,724,088	316,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	309,823	36,668,548	0.008449	10,319,386	87,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	748,914	62,083,343	0.012063	15,238,385	183,821	73.00
74.00	07400	RENAL DIALYSIS	42,917	1,568,615	0.027360	945,509	25,869	74.00
76.00	03950	ENDOSCOPY	384,845	10,810,889	0.035598	57,914	2,062	76.00
76.06	03330	IMAGING CENTER	557,556	13,142,063	0.042425	11,418	484	76.06
76.97	07697	CARDIAC REHABILITATION	16,360	1,457,627	0.011224	562	6	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	15,377	1,495,061	0.010285	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	40,153	418,581	0.095926	0	0	90.04
91.00	09100	EMERGENCY	1,081,481	123,224,365	0.008777	11,069,411	97,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	464,060	6,509,595	0.071289	519,087	37,005	92.00
200.00		Total (lines 50 through 199)	11,951,341	754,014,178		131,027,389	1,934,997	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	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 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	38,096	0.00	13,325 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,777	0.00	1,043 31.00	
43.00	04300	NURSERY	0	0	3,224	0.00	0 43.00	
200.00		Total (lines 30 through 199)	0	0	44,097	0.00	14,368 200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XVIII		Hospital		PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	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)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	101,205,888	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,887,621	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,681,902	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,928,399	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,032,118	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	52,874,382	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,450,632	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59,870,418	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,829,151	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,804,881	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,646,035	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,815,569	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	748,071	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,066,507	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,779,422	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48,014,495	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,668,548	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,083,343	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,568,615	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,810,889	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	13,142,063	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,457,627	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,495,061	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	418,581	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	123,224,365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,509,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	754,014,178		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	24,458,145	0	7,025,853	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	4,138,804	0	4,256,418	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,551,067	0	5,675,805	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	3,396,360	0	5,751,619	0	55.00	
57.00	05700 CT SCAN	0.000000	5,830,590	0	9,511,451	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	990,406	0	1,948,077	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	10,412,283	0	12,764,520	0	59.00	
60.00	06000 LABORATORY	0.000000	17,937,167	0	6,365,520	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	4,626,985	0	221,385	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,527,746	0	46,286	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,085,266	0	29,741	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	294,830	0	5,915	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,777,728	0	4,875,317	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	114,252	0	1,075,398	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	10,724,088	0	4,656,026	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,319,386	0	4,692,851	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	15,238,385	0	5,627,297	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	945,509	0	0	0	74.00	
76.00	03950 ENDOSCOPY	0.000000	57,914	0	2,539,141	0	76.00	
76.06	03330 IMAGING CENTER	0.000000	11,418	0	3,023,432	0	76.06	
76.97	07697 CARDIAC REHABILITATION	0.000000	562	0	514,589	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00	
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01	
90.02	04951 ANTI-COAGULATION CLINIC	0.000000	0	0	785,989	0	90.02	
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03	
90.04	04953 SPINE CENTER	0.000000	0	0	0	0	90.04	
91.00	09100 EMERGENCY	0.000000	11,069,411	0	14,036,718	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	519,087	0	2,593,326	0	92.00	
200.00	Total (lines 50 through 199)		131,027,389	0	98,022,674	0	200.00	



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.114378	7,025,853	0	0	803,603	50.00
51.00	05100	RECOVERY ROOM	0.166278	4,256,418	0	0	707,749	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482883	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142220	5,675,805	0	0	807,213	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.053949	5,751,619	0	0	310,294	55.00
57.00	05700	CT SCAN	0.043715	9,511,451	0	0	415,793	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.111694	1,948,077	0	0	217,589	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074915	12,764,520	0	0	956,254	59.00
60.00	06000	LABORATORY	0.101455	6,365,520	0	0	645,814	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.250090	221,385	0	0	55,366	65.00
66.00	06600	PHYSICAL THERAPY	0.382827	46,286	0	0	17,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313424	29,741	0	0	9,322	67.00
68.00	06800	SPEECH PATHOLOGY	0.315292	5,915	0	0	1,865	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098993	4,875,317	0	0	482,622	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278796	1,075,398	0	0	299,817	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346064	4,656,026	0	0	1,611,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367602	4,692,851	0	0	1,725,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262667	5,627,297	0	85,377	1,478,105	73.00
74.00	07400	RENAL DIALYSIS	0.436794	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.208076	2,539,141	0	0	528,334	76.00
76.06	03330	IMAGING CENTER	0.208091	3,023,432	0	0	629,149	76.06
76.97	07697	CARDIAC REHABILITATION	0.253169	514,589	0	0	130,278	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.331758	785,989	0	0	260,758	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.778827	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.106616	14,036,718	0	0	1,496,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.863738	2,593,326	0	0	2,239,954	92.00
200.00		Subtotal (see instructions)		98,022,674	0	85,377	15,830,522	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		98,022,674	0	85,377	15,830,522	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,426	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	0	90.04
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	22,426	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	22,426	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/30/2018 10:44 am		
Cost Center Description		Title XIX		Hospital		PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,995,183	0	3,995,183	38,096	104.87	30.00	
31.00	INTENSIVE CARE UNIT	1,088,922		1,088,922	2,777	392.12	31.00	
43.00	NURSERY	156,327		156,327	3,224	48.49	43.00	
200.00	Total (Lines 30 through 199)	5,240,432		5,240,432	44,097		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	737	77,289					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
43.00	NURSERY	1,511	73,268					43.00
200.00	Total (Lines 30 through 199)	2,248	150,557					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,792,900	101,205,888	0.017715	491,114	8,700	50.00
51.00	05100	RECOVERY ROOM	388,887	33,887,621	0.011476	152,493	1,750	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	408,983	10,681,902	0.038287	212,924	8,152	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	746,452	30,928,399	0.024135	159,401	3,847	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,449	20,032,118	0.003018	57,170	173	55.00
57.00	05700	CT SCAN	385,086	52,874,382	0.007283	244,478	1,781	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,797	10,450,632	0.018927	23,121	438	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,123,975	59,870,418	0.018773	409,819	7,694	59.00
60.00	06000	LABORATORY	289,800	74,829,151	0.003873	796,649	3,085	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	277,520	13,804,881	0.020103	273,458	5,497	65.00
66.00	06600	PHYSICAL THERAPY	622,723	8,646,035	0.072024	62,216	4,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,452	2,815,569	0.021115	29,680	627	67.00
68.00	06800	SPEECH PATHOLOGY	15,977	748,071	0.021358	11,671	249	68.00
69.00	06900	ELECTROCARDIOLOGY	271,868	23,066,507	0.011786	126,057	1,486	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	232,314	4,779,422	0.048607	7,836	381	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,415,672	48,014,495	0.029484	597,026	17,603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	309,823	36,668,548	0.008449	200,952	1,698	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	748,914	62,083,343	0.012063	972,295	11,729	73.00
74.00	07400	RENAL DIALYSIS	42,917	1,568,615	0.027360	26,148	715	74.00
76.00	03950	ENDOSCOPY	384,845	10,810,889	0.035598	10,366	369	76.00
76.06	03330	IMAGING CENTER	557,556	13,142,063	0.042425	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	16,360	1,457,627	0.011224	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	15,377	1,495,061	0.010285	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	40,153	418,581	0.095926	0	0	90.04
91.00	09100	EMERGENCY	1,081,481	123,224,365	0.008777	389,563	3,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	464,060	6,509,595	0.071289	32,845	2,341	92.00
200.00		Total (lines 50 through 199)	11,951,341	754,014,178		5,287,282	86,215	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	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 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	38,096	0.00	737 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,777	0.00	0 31.00	
43.00	04300	NURSERY	0	0	3,224	0.00	1,511 43.00	
200.00		Total (lines 30 through 199)	0	0	44,097	0.00	2,248 200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description	Title XIX				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03950 ENDOSCOPY	0	0	0	0	0	0	76.00
76.06 03330 IMAGING CENTER	0	0	0	0	0	0	76.06
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	0	90.01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	0	0	0	0	90.02
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	0	90.03
90.04 04953 SPINE CENTER	0	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	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)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	101,205,888	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,887,621	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,681,902	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,928,399	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,032,118	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	52,874,382	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,450,632	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59,870,418	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,829,151	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,804,881	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,646,035	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,815,569	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	748,071	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,066,507	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,779,422	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48,014,495	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,668,548	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,083,343	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,568,615	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,810,889	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	13,142,063	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,457,627	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,495,061	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	418,581	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	123,224,365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,509,595	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	754,014,178		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 10:44 am
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Cost Center Description		Title XIX				Hospital		
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS	
		9.00	10.00	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	491,114	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	152,493	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	212,924	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	159,401	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	57,170	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	244,478	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	23,121	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	409,819	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	796,649	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	273,458	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	62,216	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	29,680	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	11,671	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	126,057	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	7,836	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	597,026	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	200,952	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	972,295	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	26,148	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	10,366	0	0	0	76.00
76.06	03330	IMAGING CENTER	0.000000	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.000000	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	389,563	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	32,845	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,287,282	0	0	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 10:44 am
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		Title XIX		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.114378	0	444,790	0	0	50.00
51.00	05100	RECOVERY ROOM	0.166278	0	89,396	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482883	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142220	0	384,254	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.053949	0	230,783	0	0	55.00
57.00	05700	CT SCAN	0.043715	0	532,784	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.111694	0	84,506	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074915	0	250,204	0	0	59.00
60.00	06000	LABORATORY	0.101455	0	677,000	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.250090	0	25,917	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.382827	0	31,546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313424	0	9,616	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.315292	0	3,655	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098993	0	113,525	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278796	0	17,062	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346064	0	248,961	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367602	0	56,219	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262667	0	157,431	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.436794	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.208076	0	63,199	0	0	76.00
76.06	03330	IMAGING CENTER	0.208091	0	75,284	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.253169	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.331758	0	3,803	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.778827	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.106616	0	2,404,703	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.863738	0	273,931	0	0	92.00
200.00		Subtotal (see instructions)		0	6,178,569	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	6,178,569	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 10:44 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	50,874	0	50.00
51.00	05100 RECOVERY ROOM	14,865	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	54,649	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	12,451	0	55.00
57.00	05700 CT SCAN	23,291	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	9,439	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	18,744	0	59.00
60.00	06000 LABORATORY	68,685	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	6,482	0	65.00
66.00	06600 PHYSICAL THERAPY	12,077	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,014	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,152	0	68.00
69.00	06900 ELECTROCARDIOLOGY	11,238	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,757	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	86,156	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20,666	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	41,352	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	13,150	0	76.00
76.06	03330 IMAGING CENTER	15,666	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	1,262	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	256,380	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	236,605	0	92.00
200.00	Subtotal (see instructions)	962,955	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	962,955	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2018 10:44 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,096	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,096	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)		33,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		13,325	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
<b>SWING BED ADJUSTMENT</b>				
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)		48,406,164	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)		48,406,164	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		48,406,164	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,270.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,931,278	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)		16,931,278	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,401,794	2,777	2,665.39	1,043	2,780,002	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)					23,283,601	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					42,994,881	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,806,374	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,934,997	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,741,371	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					39,253,510	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)					4,425	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,270.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,622,582	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,995,183	48,406,164	0.082535	5,622,582	464,060	90.00
91.00	Nursing School cost	0	48,406,164	0.000000	5,622,582	0	91.00
92.00	Allied health cost	0	48,406,164	0.000000	5,622,582	0	92.00
93.00	All other Medical Education	0	48,406,164	0.000000	5,622,582	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2018 10:44 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,096	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,096	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)		33,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		737	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)		3,224	15.00
16.00	Nursery days (title V or XIX only)		1,511	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		48,406,164	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)		48,406,164	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		48,406,164	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,270.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		936,462	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)		936,462	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,878,405	3,224	582.63	1,511	880,354	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,401,794	2,777	2,665.39	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,074,098	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,890,914	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)					150,557	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					86,215	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					236,772	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,654,142	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)					4,425	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,270.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,622,582	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,995,183	48,406,164	0.082535	5,622,582	464,060	90.00
91.00	Nursing School cost	0	48,406,164	0.000000	5,622,582	0	91.00
92.00	Allied health cost	0	48,406,164	0.000000	5,622,582	0	92.00
93.00	All other Medical Education	0	48,406,164	0.000000	5,622,582	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		26,035,556		30.00
31.00	03100 INTENSIVE CARE UNIT		3,535,813		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.114378	24,458,145	2,797,474	50.00
51.00	05100 RECOVERY ROOM	0.166278	4,138,804	688,192	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.482883	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142220	3,551,067	505,033	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.053949	3,396,360	183,230	55.00
57.00	05700 CT SCAN	0.043715	5,830,590	254,884	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.111694	990,406	110,622	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.074915	10,412,283	780,036	59.00
60.00	06000 LABORATORY	0.101455	17,937,167	1,819,815	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.250090	4,626,985	1,157,163	65.00
66.00	06600 PHYSICAL THERAPY	0.382827	1,527,746	584,862	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313424	1,085,266	340,148	67.00
68.00	06800 SPEECH PATHOLOGY	0.315292	294,830	92,958	68.00
69.00	06900 ELECTROCARDIOLOGY	0.098993	3,777,728	373,969	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278796	114,252	31,853	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346064	10,724,088	3,711,221	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.367602	10,319,386	3,793,427	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262667	15,238,385	4,002,621	73.00
74.00	07400 RENAL DIALYSIS	0.436794	945,509	412,993	74.00
76.00	03950 ENDOSCOPY	0.208076	57,914	12,051	76.00
76.06	03330 IMAGING CENTER	0.208091	11,418	2,376	76.06
76.97	07697 CARDIAC REHABILITATION	0.253169	562	142	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.331758	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	0.778827	0	0	90.04
91.00	09100 EMERGENCY	0.106616	11,069,411	1,180,176	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.863738	519,087	448,355	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		131,027,389	23,283,601	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)		131,027,389		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 10:44 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		2,708,906	30.00
31.00	03100	INTENSIVE CARE UNIT		244,468	31.00
43.00	04300	NURSERY		127,238	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.114378	491,114	56,173 50.00
51.00	05100	RECOVERY ROOM	0.166278	152,493	25,356 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482883	212,924	102,817 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142220	159,401	22,670 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.053949	57,170	3,084 55.00
57.00	05700	CT SCAN	0.043715	244,478	10,687 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.111694	23,121	2,582 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.074915	409,819	30,702 59.00
60.00	06000	LABORATORY	0.101455	796,649	80,824 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.250090	273,458	68,389 65.00
66.00	06600	PHYSICAL THERAPY	0.382827	62,216	23,818 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313424	29,680	9,302 67.00
68.00	06800	SPEECH PATHOLOGY	0.315292	11,671	3,680 68.00
69.00	06900	ELECTROCARDIOLOGY	0.098993	126,057	12,479 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278796	7,836	2,185 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346064	597,026	206,609 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367602	200,952	73,870 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262667	972,295	255,390 73.00
74.00	07400	RENAL DIALYSIS	0.436794	26,148	11,421 74.00
76.00	03950	ENDOSCOPY	0.208076	10,366	2,157 76.00
76.06	03330	IMAGING CENTER	0.208091	0	0 76.06
76.97	07697	CARDIAC REHABILITATION	0.253169	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0 90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.331758	0	0 90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0 90.03
90.04	04953	SPINE CENTER	0.778827	0	0 90.04
91.00	09100	EMERGENCY	0.106616	389,563	41,534 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.863738	32,845	28,369 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,287,282	1,074,098 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		5,287,282	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		22,254,750	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,831,020	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)		499,335	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		9,671,325	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		156.21	4.00
<b>Indirect Medical Education Adjustment</b>				
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 § 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).		5.75	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 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 § 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)		5.75	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		5.93	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.13	11.00
12.00	Current year allowable FTE (see instructions)		6.88	12.00
13.00	Total allowable FTE count for the prior year.		3.80	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.		0.81	14.00
15.00	Sum of lines 12 through 14 divided by 3.		3.83	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		3.83	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.024518	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.024238	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.024238	21.00
22.00	IME payment adjustment (see instructions)		395,869	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		127,255	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.18	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)		395,869	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		127,255	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.46	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.10	31.00
32.00	Sum of lines 30 and 31		23.56	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.65	33.00
34.00	Disproportionate share adjustment (see instructions)		650,605	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000144967	0.000196574	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	866,536	1,330,154	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	648,121	335,272	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	983,393		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	32,614,972		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		32,742,227	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,651,296	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).		121,248	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,036	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		35,515,807	59.00
60.00	Primary payer payments		4,514	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,511,293	61.00
62.00	Deductibles billed to program beneficiaries		3,245,564	62.00
63.00	Coinurance billed to program beneficiaries		100,002	63.00
64.00	Allowable bad debts (see instructions)		164,027	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		106,618	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		55,677	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,272,345	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-155,075	70.93
70.94	HRR adjustment amount (see instructions)		-175,823	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 10:44 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			31,941,447	71.00
71.01	Sequestration adjustment (see instructions)			638,829	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			31,119,481	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, 71.02, 72, and 73)			183,137	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			275,042	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		22,426	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,830,522	2.00
3.00	OPPS payments		14,229,464	3.00
4.00	Outlier payment (see instructions)		72,036	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		22,426	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		85,377	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)		85,377	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		85,377	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		62,951	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 (see instructions)		22,426	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, 4.01, 8 and 9)		14,301,500	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,533,491	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		11,790,435	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		44,692	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		11,835,127	30.00
31.00	Primary payer payments		6,850	31.00
32.00	Subtotal (line 30 minus line 31)		11,828,277	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		289,673	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		188,287	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		247,036	36.00
37.00	Subtotal (see instructions)		12,016,564	37.00
38.00	MSP-LCC reconciliation amount from PS&R		310	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		12,016,254	40.00
40.01	Sequestration adjustment (see instructions)		240,325	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		11,539,006	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		236,923	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2018 10:44 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		31,119,481		11,539,006	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		31,119,481		11,539,006	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		183,137		236,923	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		31,302,618		11,775,929	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00



DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/30/2018 10:44 am	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			5.75	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			5.75	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			5.93	6.00
7.00	Enter the lesser of line 5 or line 6			5.75	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	5.17	0.76	5.93	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	5.01	0.74	5.75	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.93		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	5.01	1.67		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	2.54	1.24		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.77		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.52	1.23		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	2.52	1.23		17.00
18.00	Per resident amount	87,783.27	87,783.27		18.00
19.00	Approved amount for resident costs	221,214	107,973	329,187	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.18	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			329,187	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	14,368	5,051		26.00
27.00	Total Inpatient Days (see instructions)	37,107	37,107		27.00
28.00	Ratio of inpatient days to total inpatient days	0.387205	0.136120		28.00
29.00	Program direct GME amount	127,463	44,809		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		6,332		30.00
31.00	Net Program direct GME amount			165,940	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/30/2018 10:44 am
		Title XVIII	Hospital	PPS
		1.00		
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,568,615	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		42,994,881	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		4,514	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		42,990,367	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		15,852,948	42.00
43.00	Primary payer payments (see instructions)		6,850	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		15,846,098	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		58,836,465	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.730676	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.269324	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		165,940	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		121,248	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		44,692	50.00

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

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G

Date/Time Prepared:  
5/30/2018 10:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	5,999	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	183,687,374	0	0	0	4.00
5.00	Other receivable	-147,299,795	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	236,307	0	0	0	6.00
7.00	Inventory	2,929,233	0	0	0	7.00
8.00	Prepaid expenses	9,275	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	39,568,393	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	497,000	0	0	0	12.00
13.00	Land improvements	2,722,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	174,593,288	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,547,190	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	71,529,636	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	24,819	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	-120,755,751	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	115,657	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130,274,201	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	302,779,353	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	302,779,353	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	472,621,947	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,019,756	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,369,928	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,389,684	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,389,684	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	470,232,263				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)	470,232,263	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	472,621,947	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G-1

Date/Time Prepared:  
5/30/2018 10:44 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		411,123,026		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		59,109,240			2.00
3.00	Total (sum of line 1 and line 2)		470,232,266		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		470,232,266		0	11.00
12.00	ROUNDING	3		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		3		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		470,232,263		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2018 10:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	101,818,342		101,818,342	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)	101,818,342		101,818,342	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,412,158		10,412,158	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)	10,412,158		10,412,158	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	112,230,500		112,230,500	17.00
18.00	Ancillary services	299,418,790	341,983,377	641,402,167	18.00
19.00	Outpatient services	24,574,321	102,533,063	127,107,384	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	87,896	87,896	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	436,223,611	444,604,336	880,827,947	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		193,624,522		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		193,624,522		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2017  
To 12/31/2017

Worksheet G-3

Date/Time Prepared:  
5/30/2018 10:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	880,827,947	1.00
2.00	Less contractual allowances and discounts on patients' accounts	629,737,794	2.00
3.00	Net patient revenues (line 1 minus line 2)	251,090,153	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	193,624,522	4.00
5.00	Net income from service to patients (line 3 minus line 4)	57,465,631	5.00
<b>OTHER INCOME</b>			
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	8,254	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	1,635,355	24.00
25.00	Total other income (sum of lines 6-24)	1,643,609	25.00
26.00	Total (line 5 plus line 25)	59,109,240	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	59,109,240	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/30/2018 10:44 am
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,440,232	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		65,871	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)		103.11	3.00
4.00	Number of interns & residents (see instructions)		3.83	4.00
5.00	Indirect medical education percentage (see instructions)		1.06	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)		25,866	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.46	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		21.10	8.00
9.00	Sum of lines 7 and 8		23.56	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.89	10.00
11.00	Disproportionate share adjustment (see instructions)		119,327	11.00
12.00	Total prospective capital payments (see instructions)		2,651,296	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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