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: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 10/19/2017 9:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/19/2017 Time: 9:37 am
2. [ ] Manually submitted cost report
3. [1] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF BREMEN, INC. (15-1300) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 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.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	140,175	174,281	0	-2,304	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	765	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	140,940	174,281	0	-2,304	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: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 10/19/2017 9:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1020 HIGH RD	PO Box: 8			1.00
2.00	City: BREMEN	State: IN	Zip Code: 46506-	County: MARSHALL	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COMMUNITY HOSPITAL OF BREMEN, INC.	151300	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY HOSPITAL SWING BED	15Z300	99915		05/01/1984	N	O	N	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)	05/01/2016	04/30/2017	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 10/19/2017 9:35 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.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 10/19/2017 9:35 am

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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 10/19/2017 9:35 am

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	173,397	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 10/19/2017 9:35 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 10/19/2017 9:35 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/01/2016	04/30/2017	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 10/19/2017 9:35 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	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N	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)	Y	06/15/2017	Y	06/15/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 10/19/2017 9:35 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM		43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 10/19/2017 9:35 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	17,424.00	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)		24	8,760	17,424.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		24	8,760	17,424.00	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)		24				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 10/19/2017 9:35 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)	309	10	726			1.00
2.00	HMO and other (see instructions)	0	131				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	198	0	202			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	15			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	507	10	943			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		14	242			13.00
14.00	Total (see instructions)	507	24	1,185	0.00	138.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	138.66	27.00
28.00	Observation Bed Days		0	384			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 10/19/2017 9:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	111	14	337	1.00
2.00	HMO and other (see instructions)			0	67		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	111	14	337	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-10 | Date/Time Prepared: 10/19/2017 9:35 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.472702	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	727,596	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,868,844	6.00
7.00	Medicaid cost (line 1 times line 6)	1,828,810	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)	1,101,214	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,101,214	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	226,609	0	226,609	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	107,119	0	107,119	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	107,119	0	107,119	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, 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)	1,200,083	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	99,791	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	153,524	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,046,559	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	548,444	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	655,563	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,756,777	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,394,510	1,394,510	0	1,394,510	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	88,553	2,773,076	2,861,629	0	2,861,629	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,388,242	1,640,247	3,028,489	0	3,028,489	5.00
7.00	00700	OPERATION OF PLANT	186,723	505,377	692,100	-4,951	687,149	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	135,277	135,277	0	135,277	8.00
9.00	00900	HOUSEKEEPING	162,563	23,734	186,297	-9,874	176,423	9.00
10.00	01000	DIETARY	224,441	265,930	490,371	-412,358	78,013	10.00
11.00	01100	CAFETERIA	0	0	0	412,358	412,358	11.00
13.00	01300	NURSING ADMINISTRATION	144,777	18,058	162,835	-22	162,813	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,677	92,260	333,937	0	333,937	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	861,050	163,799	1,024,849	-143,535	881,314	30.00
43.00	04300	NURSERY	0	0	0	41,406	41,406	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	978,151	792,148	1,770,299	-391,586	1,378,713	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	84,365	84,365	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	580,446	362,198	942,644	-10,207	932,437	54.00
57.00	05700	CT SCAN	30,495	200,708	231,203	-3,801	227,402	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,103	311,816	368,919	-4,401	364,518	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	920,290	1,090,659	2,010,949	-263	2,010,686	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	11,126	31,791	42,917	0	42,917	64.00
65.00	06500	RESPIRATORY THERAPY	0	20,787	20,787	0	20,787	65.00
66.00	06600	PHYSICAL THERAPY	274,987	15,521	290,508	-2,715	287,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0	65,590	65,590	0	65,590	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,003	3,094	119,097	171,593	290,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	271,800	271,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	204,837	419,845	624,682	0	624,682	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,059,107	78,591	2,137,698	-11,536	2,126,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,530,571	10,405,016	18,935,587	-13,727	18,921,860	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,060,945	400,563	1,461,508	13,727	1,475,235	192.00
200.00		TOTAL (SUM OF LINES 118-199)	9,591,516	10,805,579	20,397,095	0	20,397,095	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-202,674	1,191,836		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-87,155	2,774,474		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-346,721	2,681,768		5.00
7.00	00700	OPERATION OF PLANT	0	687,149		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	135,277		8.00
9.00	00900	HOUSEKEEPING	0	176,423		9.00
10.00	01000	DIETARY	-7,835	70,178		10.00
11.00	01100	CAFETERIA	-188,005	224,353		11.00
13.00	01300	NURSING ADMINISTRATION	0	162,813		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,141	331,796		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	881,314		30.00
43.00	04300	NURSERY	0	41,406		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-418,314	960,399		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	84,365		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	932,437		54.00
57.00	05700	CT SCAN	0	227,402		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	364,518		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,010,686		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	42,917		64.00
65.00	06500	RESPIRATORY THERAPY	0	20,787		65.00
66.00	06600	PHYSICAL THERAPY	0	287,793		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
69.02	06902	SLEEP LAB	0	65,590		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	290,690		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	271,800		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,669	622,013		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-831,543	1,294,619		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,087,057	16,834,803		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,475,235		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,087,057	18,310,038		200.00

RECLASSIFICATIONS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 10/19/2017 9:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	271,800		1.00
	0		0	271,800		
	B - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	443,393		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	0		0	443,393		
	C - OB/NURSERY RECLASS					
1.00	NURSERY	43.00	25,857	15,549		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	52,684	31,681		2.00
	0		78,541	47,230		
	D - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	188,735	223,623		1.00
	0		188,735	223,623		
	F - HOUSEKEEPING RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	9,869	0		1.00
	0		9,869	0		
	G - MAINTENANCE RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	4,951	0		1.00
	0		4,951	0		
500.00	Grand Total: Increases		282,096	986,046		500.00

RECLASSIFICATIONS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 10/19/2017 9:35 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	271,800	0		1.00
	0		0	271,800			
	B - CHARGABLE SUPPLIES						
1.00	HOUSEKEEPING	9.00	0	5	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	22	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	17,764	0		3.00
4.00	OPERATING ROOM	50.00	0	391,586	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,207	0		5.00
6.00	CT SCAN	57.00	0	3,801	0		6.00
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,401	0		7.00
8.00	LABORATORY	60.00	0	263	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	2,715	0		9.00
10.00	EMERGENCY	91.00	0	11,536	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,093	0		11.00
	0		0	443,393			
	C - OB/NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	78,541	47,230	0		1.00
2.00		0.00	0	0	0		2.00
	0		78,541	47,230			
	D - CAFETERIA RECLASS						
1.00	DIETARY	10.00	188,735	223,623	0		1.00
	0		188,735	223,623			
	F - HOUSEKEEPING RECLASS						
1.00	HOUSEKEEPING	9.00	9,869	0	0		1.00
	0		9,869	0			
	G - MAINTENANCE RECLASS						
1.00	OPERATION OF PLANT	7.00	4,951	0	0		1.00
	0		4,951	0			
500.00	Grand Total: Decreases		282,096	986,046			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 10/19/2017 9:35 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	440,038	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,937,043	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,377,934	233,848	0	233,848	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,755,015	233,848	0	233,848	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,755,015	233,848	0	233,848	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	440,038	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	17,937,043	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,611,782	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,988,863	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	25,988,863	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 10/19/2017 9:35 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	NEW CAP REL COSTS-BLDG & FIXT	771,607	0	586,370	0	36,533	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	771,607	0	586,370	0	36,533	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,394,510		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,394,510		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 10/19/2017 9:35 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	NEW CAP REL COSTS-BLDG & FIXT	18,377,081	0	18,377,081	0.707114	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,611,782	0	7,611,782	0.292886	0	2.00
3.00	Total (sum of lines 1-2)	25,988,863	0	25,988,863	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	684,602	-77,400	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	684,602	-77,400	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	NEW CAP REL COSTS-BLDG & FIXT	548,101	0	36,533	0	1,191,836	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	548,101	0	36,533	0	1,191,836	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 10/19/2017 9:35 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-38,269	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-17,981	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-904,578			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-188,005	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,669	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,141	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 10/19/2017 9:35 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	
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	A	-41,285	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	MEALS ON WHEELS	B	-7,835	DIETARY	10.00	0	33.00
34.00	HAF PROVIDER ASSESSMENT	A	-188,470	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	INVOICE PENALTIES	A	-8,398	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RECRUITING/MD SUPPORT	A	-110,000	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	LOBBYING EXP IN DUES	A	-1,859	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PLYMOUTH ST CLINIC DEPR	A	-24,612	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
38.01	WATERFORD FAMILY MEDICINE	A	-21,108	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	38.01
39.00	MISC INCOME	B	-19,797	ADMINISTRATIVE & GENERAL	5.00	0	39.00
41.00	SALES TAX	B	-96	ADMINISTRATIVE & GENERAL	5.00	0	41.00
45.00	OTHER OPER REV-COMMUNITY GR	B	-120	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	RENTAL REVENUE-SPECIALISTS	B	-77,400	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	45.01
45.03	CRNA SALARIES	A	-345,279	OPERATING ROOM	50.00	0	45.03
45.04	CRNA BENEFITS	A	-87,155	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,087,057				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 10/19/2017 9:35 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	50.00	OPERATING ROOM	73,035	73,035	0	0	0	1.00
2.00	91.00	EMERGENCY	1,596,972	831,543	765,429	0	0	2.00
3.00	60.00	LABORATORY	26,400	0	26,400	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			1,696,407	904,578	791,829		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	73,035		1.00
2.00	91.00	EMERGENCY	0	0	0	831,543		2.00
3.00	60.00	LABORATORY	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	0	0	904,578		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 10/19/2017 9:35 am

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	1	1.00
2.00	Line 1 multiplied by 15 hours per week	15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	1	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	8.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.65	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.83	39.83	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	637	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	637	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	637	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	79.63	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	1,194	22.00
23.00	Total salary equivalency (see instructions)	1,194	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	40	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	40	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	40	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	40	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 10/19/2017 9:35 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.65	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		1,194	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		40	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		1,234	63.00
64.00	Total cost of outside supplier services (from your records)		496	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		40	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		40	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 10/19/2017 9:35 am

		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		6	1.00
2.00	Line 1 multiplied by 15 hours per week		90	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		10	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	14.46	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.57	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.29	38.29	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		1,107	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		1,107	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		1,107	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		76.56	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		6,890	22.00
23.00	Total salary equivalency (see instructions)		6,890	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		383	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		383	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		383	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		383	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/19/2017 9:35 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.57	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	6,890		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	383		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	7,273		63.00
64.00	Total cost of outside supplier services (from your records)	838		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	383		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	383		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,191,836	1,191,836				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,774,474	4,457	0	2,778,931		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,681,768	99,419	0	405,961	3,187,148	5.00
7.00	00700	OPERATION OF PLANT	687,149	215,103	0	53,155	955,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	135,277	4,245	0	0	139,522	8.00
9.00	00900	HOUSEKEEPING	176,423	7,293	0	44,652	228,368	9.00
10.00	01000	DIETARY	70,178	24,368	0	10,441	104,987	10.00
11.00	01100	CAFETERIA	224,353	24,233	0	55,191	303,777	11.00
13.00	01300	NURSING ADMINISTRATION	162,813	7,698	0	42,337	212,848	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	331,796	12,772	0	70,673	415,241	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	881,314	235,825	0	228,828	1,345,967	30.00
43.00	04300	NURSERY	41,406	5,634	0	7,561	54,601	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	960,399	161,274	0	286,039	1,407,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,365	0	0	15,406	99,771	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	932,437	76,846	0	169,739	1,179,022	54.00
57.00	05700	CT SCAN	227,402	0	0	8,918	236,320	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	364,518	0	0	16,699	381,217	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,010,686	46,497	0	269,119	2,326,302	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	42,917	5,788	0	3,254	51,959	64.00
65.00	06500	RESPIRATORY THERAPY	20,787	0	0	0	20,787	65.00
66.00	06600	PHYSICAL THERAPY	287,793	54,330	0	80,414	422,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,389	0	0	1,389	69.00
69.02	06902	SLEEP LAB	65,590	8,663	0	0	74,253	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	290,690	41,018	0	33,923	365,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	271,800	0	0	0	271,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	622,013	15,415	0	59,900	697,328	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,294,619	131,466	0	602,137	2,028,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,834,803	1,183,733	0	2,464,347	16,512,116	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,103	0	0	8,103	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,475,235	0	0	314,584	1,789,819	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	18,310,038	1,191,836	0	2,778,931	18,310,038	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,187,148					5.00
7.00	00700	OPERATION OF PLANT	201,352	1,156,759				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,404	5,625	174,551			8.00
9.00	00900	HOUSEKEEPING	48,129	9,665	13,474	299,636		9.00
10.00	01000	DIETARY	22,126	32,293	453	8,477	168,336	10.00
11.00	01100	CAFETERIA	64,021	32,114	517	8,430	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,858	10,202	0	2,678	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87,512	16,927	0	4,443	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	283,663	312,528	49,644	82,040	168,336	30.00
43.00	04300	NURSERY	11,507	7,466	267	1,960	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	296,675	213,730	52,698	56,104	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,027	0	347	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,479	101,841	17,101	26,733	0	54.00
57.00	05700	CT SCAN	49,804	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	80,341	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	490,266	61,621	0	16,175	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	10,950	7,671	0	2,014	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,381	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	89,050	72,002	10,659	18,900	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	293	1,841	629	483	0	69.00
69.02	06902	SLEEP LAB	15,649	11,480	380	3,014	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,057	54,359	0	14,269	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,282	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,962	20,429	0	5,363	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	427,448	174,226	26,108	45,734	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,808,236	1,146,020	172,277	296,817	168,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,708	10,739	0	2,819	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	377,204	0	2,274	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,187,148	1,156,759	174,551	299,636	168,336	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
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	408,859					11.00
13.00	01300	NURSING ADMINISTRATION	6,910	277,496				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,818	0	547,941			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,561	92,765	47,401	2,435,905	0	30.00
43.00	04300	NURSERY	1,516	2,625	3,974	83,916	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,691	82,598	103,871	2,261,079	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,089	5,350	8,097	137,681	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,368	0	45,889	1,657,433	0	54.00
57.00	05700	CT SCAN	2,083	0	50,299	338,506	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,324	0	22,677	488,559	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	101,067	0	153,918	3,149,349	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	79	0	1,955	74,628	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	655	25,823	0	65.00
66.00	06600	PHYSICAL THERAPY	15,462	0	19,286	647,896	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,881	10,516	0	69.00
69.02	06902	SLEEP LAB	0	0	5,297	110,073	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,022	0	11,541	534,879	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,306	340,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,041	12,194	24,889	914,206	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	51,655	81,964	31,005	2,866,362	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	368,686	277,496	547,941	16,077,199	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	23,369	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,173	0	0	2,209,470	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	408,859	277,496	547,941	18,310,038	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,435,905		30.00
43.00	04300	NURSERY	83,916		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,261,079		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,681		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,657,433		54.00
57.00	05700	CT SCAN	338,506		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	488,559		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	3,149,349		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
64.00	06400	INTRAVENOUS THERAPY	74,628		64.00
65.00	06500	RESPIRATORY THERAPY	25,823		65.00
66.00	06600	PHYSICAL THERAPY	647,896		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	10,516		69.00
69.02	06902	SLEEP LAB	110,073		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	534,879		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	340,388		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	914,206		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	2,866,362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,077,199		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	23,369		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,209,470		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	18,310,038		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,457	0	4,457	4,457	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	99,419	0	99,419	651	5.00
7.00	00700	OPERATION OF PLANT	0	215,103	0	215,103	85	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,245	0	4,245	0	8.00
9.00	00900	HOUSEKEEPING	0	7,293	0	7,293	72	9.00
10.00	01000	DIETARY	0	24,368	0	24,368	17	10.00
11.00	01100	CAFETERIA	0	24,233	0	24,233	89	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,698	0	7,698	68	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,772	0	12,772	113	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	235,825	0	235,825	367	30.00
43.00	04300	NURSERY	0	5,634	0	5,634	12	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	161,274	0	161,274	459	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	25	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,846	0	76,846	272	54.00
57.00	05700	CT SCAN	0	0	0	0	14	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	27	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	46,497	0	46,497	432	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	5,788	0	5,788	5	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	54,330	0	54,330	129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,389	0	1,389	0	69.00
69.02	06902	SLEEP LAB	0	8,663	0	8,663	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,018	0	41,018	54	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,415	0	15,415	96	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	131,466	0	131,466	965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,183,733	0	1,183,733	3,952	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,103	0	8,103	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	505	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,191,836	0	1,191,836	4,457	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	100,070					5.00
7.00	00700	OPERATION OF PLANT	6,322	221,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	923	1,077	6,245			8.00
9.00	00900	HOUSEKEEPING	1,511	1,851	482	11,209		9.00
10.00	01000	DIETARY	695	6,184	16	317	31,597	10.00
11.00	01100	CAFETERIA	2,010	6,150	18	315	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,408	1,954	0	100	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,748	3,241	0	166	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,906	59,845	1,776	3,070	31,597	30.00
43.00	04300	NURSERY	361	1,430	10	73	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,315	40,928	1,886	2,099	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	660	0	12	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,802	19,502	612	1,000	0	54.00
57.00	05700	CT SCAN	1,564	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,523	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	15,394	11,800	0	605	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	344	1,469	0	75	0	64.00
65.00	06500	RESPIRATORY THERAPY	138	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,796	13,788	381	707	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9	353	23	18	0	69.00
69.02	06902	SLEEP LAB	491	2,198	14	113	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,419	10,409	0	534	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,799	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,614	3,912	0	201	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,421	33,363	934	1,711	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,173	219,454	6,164	11,104	31,597	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	54	2,056	0	105	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,843	0	81	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	100,070	221,510	6,245	11,209	31,597	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
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	32,815					11.00
13.00	01300	NURSING ADMINISTRATION	555	11,783				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,912	0	20,952			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,299	3,940	1,812	351,437	0	30.00
43.00	04300	NURSERY	122	111	152	7,905	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,828	3,507	3,971	227,267	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	248	227	310	1,482	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,079	0	1,755	110,868	0	54.00
57.00	05700	CT SCAN	167	0	1,923	3,668	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	347	0	867	3,764	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,111	0	5,887	88,726	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	6	0	75	7,762	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	25	163	0	65.00
66.00	06600	PHYSICAL THERAPY	1,241	0	737	74,109	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	225	2,017	0	69.00
69.02	06902	SLEEP LAB	0	0	203	11,682	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	965	0	441	55,840	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	432	2,231	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565	518	952	26,273	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,146	3,480	1,185	190,671	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,591	11,783	20,952	1,165,865	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	10,318	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,224	0	0	15,653	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	32,815	11,783	20,952	1,191,836	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	351,437		30.00
43.00	04300	NURSERY	7,905		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	227,267		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,482		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,868		54.00
57.00	05700	CT SCAN	3,668		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,764		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	88,726		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
64.00	06400	INTRAVENOUS THERAPY	7,762		64.00
65.00	06500	RESPIRATORY THERAPY	163		65.00
66.00	06600	PHYSICAL THERAPY	74,109		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,017		69.00
69.02	06902	SLEEP LAB	11,682		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,840		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,231		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,273		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	190,671		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,165,865		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	10,318		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,653		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,191,836		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FOOTAGE)	NEW MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	61,774					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		61,774				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	231	231	9,502,963			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,153	5,153	1,388,242	-3,187,148	15,122,890	5.00
7.00	00700	OPERATION OF PLANT	11,149	11,149	181,772	0	955,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	220	220	0	0	139,522	8.00
9.00	00900	HOUSEKEEPING	378	378	152,694	0	228,368	9.00
10.00	01000	DIETARY	1,263	1,263	35,706	0	104,987	10.00
11.00	01100	CAFETERIA	1,256	1,256	188,735	0	303,777	11.00
13.00	01300	NURSING ADMINISTRATION	399	399	144,777	0	212,848	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662	662	241,677	0	415,241	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,223	12,223	782,509	0	1,345,967	30.00
43.00	04300	NURSERY	292	292	25,857	0	54,601	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,359	8,359	978,151	0	1,407,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52,684	0	99,771	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,983	3,983	580,446	0	1,179,022	54.00
57.00	05700	CT SCAN	0	0	30,495	0	236,320	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	57,103	0	381,217	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,410	2,410	920,290	0	2,326,302	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	300	300	11,126	0	51,959	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	20,787	65.00
66.00	06600	PHYSICAL THERAPY	2,816	2,816	274,987	0	422,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	72	72	0	0	1,389	69.00
69.02	06902	SLEEP LAB	449	449	0	0	74,253	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,126	2,126	116,003	0	365,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	271,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	799	799	204,837	0	697,328	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,814	6,814	2,059,107	0	2,028,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,354	61,354	8,427,198	-3,187,148	13,324,968	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	420	0	0	8,103	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,075,765	0	1,789,819	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,191,836	0	2,778,931		3,187,148	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.293489	0.000000	0.292428		0.210750	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,457		100,070	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000469		0.006617	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE HRS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	45,241					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	220	79,065				8.00
9.00	00900	HOUSEKEEPING	378	6,103	44,643			9.00
10.00	01000	DIETARY	1,263	205	1,263	3,744		10.00
11.00	01100	CAFETERIA	1,256	234	1,256	0	190,992	11.00
13.00	01300	NURSING ADMINISTRATION	399	0	399	0	3,228	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662	0	662	0	11,126	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,223	22,487	12,223	3,744	25,020	30.00
43.00	04300	NURSERY	292	121	292	0	708	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,359	23,871	8,359	0	22,278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	157	0	0	1,443	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,983	7,746	3,983	0	17,923	54.00
57.00	05700	CT SCAN	0	0	0	0	973	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	2,020	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,410	0	2,410	0	47,212	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	300	0	300	0	37	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,816	4,828	2,816	0	7,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	72	285	72	0	0	69.00
69.02	06902	SLEEP LAB	449	172	449	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,126	0	2,126	0	5,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	799	0	799	0	3,289	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,814	11,826	6,814	0	24,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,821	78,035	44,223	3,744	172,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	0	420	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,030	0	0	18,766	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,156,759	174,551	299,636	168,336	408,859	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.568820	2.207690	6.711825	44.961538	2.140713	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	221,510	6,245	11,209	31,597	32,815	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.896222	0.078986	0.251081	8.439370	0.171813	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 10/19/2017 9:35 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
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	74,845			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,011,274		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	25,020	2,942,159		30.00
43.00	04300	NURSERY	708	246,649		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	22,278	6,447,200		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,443	502,554		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,848,278		54.00
57.00	05700	CT SCAN	0	3,121,999		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,407,577		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	9,554,618		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	121,335		64.00
65.00	06500	RESPIRATORY THERAPY	0	40,645		65.00
66.00	06600	PHYSICAL THERAPY	0	1,197,077		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	365,018		69.00
69.02	06902	SLEEP LAB	0	328,811		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	716,339		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	701,737		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,289	1,544,833		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	22,107	1,924,445		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,845	34,011,274		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	277,496	547,941		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.707609	0.016111		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,783	20,952		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.157432	0.000616		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,435,905		2,435,905	0	0	30.00
43.00	04300	NURSERY	83,916		83,916	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,261,079		2,261,079	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,681		137,681	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,657,433		1,657,433	0	0	54.00
57.00	05700	CT SCAN	338,506		338,506	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	488,559		488,559	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,149,349		3,149,349	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	74,628		74,628	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,823	0	25,823	0	0	65.00
66.00	06600	PHYSICAL THERAPY	647,896	0	647,896	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,516		10,516	0	0	69.00
69.02	06902	SLEEP LAB	110,073		110,073	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	534,879		534,879	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	340,388		340,388	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	914,206		914,206	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,866,362		2,866,362	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	712,343		712,343		0	92.00
200.00		Subtotal (see instructions)	16,789,542	0	16,789,542	0	0	200.00
201.00		Less Observation Beds	712,343		712,343		0	201.00
202.00		Total (see instructions)	16,077,199	0	16,077,199	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,775,256		1,775,256			30.00
43.00	04300	NURSERY	246,649		246,649			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,713,972	4,733,228	6,447,200	0.350707	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	474,035	28,519	502,554	0.273963	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,016	2,783,262	2,848,278	0.581907	0.000000	54.00
57.00	05700	CT SCAN	106,567	3,015,432	3,121,999	0.108426	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	44,992	1,362,585	1,407,577	0.347092	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	380,643	9,173,975	9,554,618	0.329615	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	121,335	121,335	0.615057	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	8,281	32,364	40,645	0.635330	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	212,235	984,842	1,197,077	0.541232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	37,506	327,512	365,018	0.028810	0.000000	69.00
69.02	06902	SLEEP LAB	0	328,811	328,811	0.334761	0.000000	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	256,337	460,002	716,339	0.746684	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	462,059	239,678	701,737	0.485065	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,322	1,122,511	1,544,833	0.591783	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	26,693	1,897,752	1,924,445	1.489449	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,328	1,161,575	1,166,903	0.610456	0.000000	92.00
200.00		Subtotal (see instructions)	6,237,891	27,773,383	34,011,274			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,237,891	27,773,383	34,011,274			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.02	06902	SLEEP LAB	0.000000		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,435,905		2,435,905	0	2,435,905	30.00
43.00	04300	NURSERY	83,916		83,916	0	83,916	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,261,079		2,261,079	0	2,261,079	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,681		137,681	0	137,681	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,657,433		1,657,433	0	1,657,433	54.00
57.00	05700	CT SCAN	338,506		338,506	0	338,506	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	488,559		488,559	0	488,559	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,149,349		3,149,349	0	3,149,349	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	74,628		74,628	0	74,628	64.00
65.00	06500	RESPIRATORY THERAPY	25,823	0	25,823	0	25,823	65.00
66.00	06600	PHYSICAL THERAPY	647,896	0	647,896	0	647,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,516		10,516	0	10,516	69.00
69.02	06902	SLEEP LAB	110,073		110,073	0	110,073	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	534,879		534,879	0	534,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	340,388		340,388	0	340,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	914,206		914,206	0	914,206	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,866,362		2,866,362	0	2,866,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	712,343		712,343		712,343	92.00
200.00		Subtotal (see instructions)	16,789,542	0	16,789,542	0	16,789,542	200.00
201.00		Less Observation Beds	712,343		712,343		712,343	201.00
202.00		Total (see instructions)	16,077,199	0	16,077,199	0	16,077,199	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,775,256		1,775,256			30.00
43.00	04300	NURSERY	246,649		246,649			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,713,972	4,733,228	6,447,200	0.350707	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	474,035	28,519	502,554	0.273963	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,016	2,783,262	2,848,278	0.581907	0.000000	54.00
57.00	05700	CT SCAN	106,567	3,015,432	3,121,999	0.108426	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	44,992	1,362,585	1,407,577	0.347092	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	380,643	9,173,975	9,554,618	0.329615	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	121,335	121,335	0.615057	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	8,281	32,364	40,645	0.635330	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	212,235	984,842	1,197,077	0.541232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	37,506	327,512	365,018	0.028810	0.000000	69.00
69.02	06902	SLEEP LAB	0	328,811	328,811	0.334761	0.000000	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	256,337	460,002	716,339	0.746684	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	462,059	239,678	701,737	0.485065	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,322	1,122,511	1,544,833	0.591783	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	26,693	1,897,752	1,924,445	1.489449	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,328	1,161,575	1,166,903	0.610456	0.000000	92.00
200.00		Subtotal (see instructions)	6,237,891	27,773,383	34,011,274			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,237,891	27,773,383	34,011,274			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.02	06902	SLEEP LAB	0.000000		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part II Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	227,267	6,447,200	0.035250	427,727	15,077	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,482	502,554	0.002949	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,868	2,848,278	0.038925	30,607	1,191	54.00
57.00	05700	CT SCAN	3,668	3,121,999	0.001175	43,122	51	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,764	1,407,577	0.002674	16,112	43	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	88,726	9,554,618	0.009286	126,037	1,170	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	7,762	121,335	0.063972	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	163	40,645	0.004010	2,366	9	65.00
66.00	06600	PHYSICAL THERAPY	74,109	1,197,077	0.061908	72,540	4,491	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,017	365,018	0.005526	2,424	13	69.00
69.02	06902	SLEEP LAB	11,682	328,811	0.035528	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,840	716,339	0.077952	54,799	4,272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,231	701,737	0.003179	233,709	743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,273	1,544,833	0.017007	164,432	2,796	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	190,671	1,924,445	0.099078	9,442	935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	102,773	1,166,903	0.088073	0	0	92.00
200.00		Total (lines 50-199)	909,296	31,989,369		1,183,317	30,791	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,447,200	0.000000	0.000000	427,727	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	502,554	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,848,278	0.000000	0.000000	30,607	54.00
57.00	05700	CT SCAN	0	3,121,999	0.000000	0.000000	43,122	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,407,577	0.000000	0.000000	16,112	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,554,618	0.000000	0.000000	126,037	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	121,335	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	40,645	0.000000	0.000000	2,366	65.00
66.00	06600	PHYSICAL THERAPY	0	1,197,077	0.000000	0.000000	72,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	365,018	0.000000	0.000000	2,424	69.00
69.02	06902	SLEEP LAB	0	328,811	0.000000	0.000000	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	716,339	0.000000	0.000000	54,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	701,737	0.000000	0.000000	233,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,544,833	0.000000	0.000000	164,432	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,924,445	0.000000	0.000000	9,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,166,903	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	31,989,369			1,183,317	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.02	06902	SLEEP LAB	0	0	0		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.350707	0	899,351	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273963	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.581907	0	714,121	0	0	54.00
57.00	05700	CT SCAN	0.108426	0	790,116	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.347092	0	370,908	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.329615	0	4,608,846	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.615057	0	40,273	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635330	0	9,100	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.541232	0	312,403	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028810	0	68,911	0	0	69.00
69.02	06902	SLEEP LAB	0.334761	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.746684	0	95,697	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485065	0	74,797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.591783	0	569,551	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.489449	0	409,628	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.610456	0	468,431	0	0	92.00
200.00		Subtotal (see instructions)		0	9,432,133	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,432,133	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	315,409	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,552	0		54.00
57.00	05700	CT SCAN	85,669	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,739	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	1,519,145	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	24,770	0		64.00
65.00	06500	RESPIRATORY THERAPY	5,782	0		65.00
66.00	06600	PHYSICAL THERAPY	169,083	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	1,985	0		69.00
69.02	06902	SLEEP LAB	0	0		69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,455	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,281	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,051	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	610,120	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,957	0		92.00
200.00		Subtotal (see instructions)	4,006,998	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,006,998	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1300 | Component CCN: 15-Z300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.350707	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273963	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.581907	0	0	0	0	54.00
57.00	05700	CT SCAN	0.108426	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.347092	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.329615	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.615057	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635330	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.541232	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028810	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0.334761	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.746684	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485065	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.591783	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.489449	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.610456	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1300 | Component CCN: 15-Z300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
60.01	06001	BLOOD LABORATORY	0	0		60.01
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
69.02	06902	SLEEP LAB	0	0		69.02
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	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,327	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,110	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)	726	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	135	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)	67	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	309	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)	132	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)	66	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.30	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.30	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,435,905	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)	1,373	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)	686	25.00
26.00	Total swing-bed cost (see instructions)	376,783	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,059,122	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,059,122	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,855.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	573,217	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)	573,217	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

	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						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)	526,116	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,099,333	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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)	244,869	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	122,435	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	367,304	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)	384	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,855.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	712,343	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	351,437	2,435,905	0.144274	712,343	102,773	90.00
91.00	Nursing School cost	0	2,435,905	0.000000	712,343	0	91.00
92.00	Allied health cost	0	2,435,905	0.000000	712,343	0	92.00
93.00	All other Medical Education	0	2,435,905	0.000000	712,343	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,327	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,110	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)	726	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)	202	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)	15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10	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)	242	15.00
16.00	Nursery days (title V or XIX only)	14	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.30	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,435,905	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)	375,039	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,060,866	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,060,866	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,856.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	18,566	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)	18,566	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

	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)	83,916	242	346.76	14	4,855	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	21,496	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44,917	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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)	384	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,856.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	712,950	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	351,437	2,435,905	0.144274	712,950	102,860	90.00
91.00	Nursing School cost	0	2,435,905	0.000000	712,950	0	91.00
92.00	Allied health cost	0	2,435,905	0.000000	712,950	0	92.00
93.00	All other Medical Education	0	2,435,905	0.000000	712,950	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		509,859		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.350707	427,727	150,007	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273963	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.581907	30,607	17,810	54.00
57.00	05700	CT SCAN	0.108426	43,122	4,676	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.347092	16,112	5,592	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.329615	126,037	41,544	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.615057	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635330	2,366	1,503	65.00
66.00	06600	PHYSICAL THERAPY	0.541232	72,540	39,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028810	2,424	70	69.00
69.02	06902	SLEEP LAB	0.334761	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.746684	54,799	40,918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485065	233,709	113,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.591783	164,432	97,308	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.489449	9,442	14,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.610456	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,183,317	526,116	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,183,317		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1300 | Component CCN: 15-Z300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.350707	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273963	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.581907	2,727	1,587	54.00
57.00	05700	CT SCAN	0.108426	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.347092	9,406	3,265	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.329615	23,582	7,773	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.615057	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635330	2,912	1,850	65.00
66.00	06600	PHYSICAL THERAPY	0.541232	91,388	49,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028810	0	0	69.00
69.02	06902	SLEEP LAB	0.334761	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.746684	2,718	2,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485065	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.591783	73,914	43,741	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.489449	4	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.610456	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		206,651	109,713	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)		206,651		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 10/19/2017 9:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		59,167		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.350707	44,047	15,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273963	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.581907	311	181	54.00
57.00	05700	CT SCAN	0.108426	1,030	112	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.347092	126	44	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.329615	7,562	2,493	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.615057	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.635330	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.541232	5,474	2,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.028810	57	2	69.00
69.02	06902	SLEEP LAB	0.334761	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.746684	59	44	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485065	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.591783	118	70	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.489449	93	139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.610456	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,877	21,496	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)		58,877		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part B Date/Time Prepared: 10/19/2017 9:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,006,998	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,006,998	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,047,068	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	33,460	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	956,698	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)	3,056,910	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,056,910	30.00
31.00	Primary payer payments	1,875	31.00
32.00	Subtotal (line 30 minus line 31)	3,055,035	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	141,755	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	92,141	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	112,020	36.00
37.00	Subtotal (see instructions)	3,147,176	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,147,176	40.00
40.01	Sequestration adjustment (see instructions)	62,944	40.01
41.00	Interim payments	2,909,951	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	174,281	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Hospital | Cost

		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		784,712		2,909,951	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	11/11/2016	52,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		52,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		837,312		2,909,951	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		140,175		174,281	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		977,487		3,084,232	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1300 | Component CCN: 15-Z300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Swing Beds - SNF | Cost

		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		415,723		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/27/2016	52,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		52,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		468,323		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		765		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		469,088		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet E-1 Part II Date/Time Prepared: 10/19/2017 9:35 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	337	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	309	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	726	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	34,011,274	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	226,609	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1300 | Component CCN: 15-Z300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-2 | Date/Time Prepared: 10/19/2017 9:35 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	370,977	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	110,810	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	198	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	481,787	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	481,787	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	481,787	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,126	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	478,661	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	478,661	0	19.00
19.01	Sequestration adjustment (see instructions)	9,573	0	19.01
20.00	Interim payments	468,323	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	765	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet E-3 Part V Date/Time Prepared: 10/19/2017 9:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,099,333	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,099,333	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,110,326	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,110,326	19.00
20.00	Deductibles (exclude professional component)	120,540	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	989,786	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	989,786	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,769	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,650	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,120	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	997,436	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	997,436	30.00
30.01	Sequestration adjustment (see instructions)	19,949	30.01
31.00	Interim payments	837,312	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	140,175	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1300	Period: From 05/01/2016 To 04/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 10/19/2017 9:35 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	44,917		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	44,917	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	44,917	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	59,167		8.00
9.00	Ancillary service charges	58,877	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	118,044	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	118,044	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	73,127	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	44,917	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	44,917	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	44,917	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	44,917	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	44,917	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	44,917	0	40.00
41.00	Interim payments	47,221	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,304	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G | Date/Time Prepared: 10/19/2017 9:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	340,127	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	6,289,829	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,545,553	0	0	0	6.00
7.00	Inventory	134,036	0	0	0	7.00
8.00	Prepaid expenses	190,546	0	0	0	8.00
9.00	Other current assets	66,287	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)	3,475,272	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	440,038	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	17,937,043	0	0	0	15.00
16.00	Accumulated depreciation	-5,174,861	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,611,782	0	0	0	23.00
24.00	Accumulated depreciation	-6,820,334	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,993,668	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	913,212	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	913,212	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,382,152	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	551,708	0	0	0	37.00
38.00	Salaries, wages, and fees payable	851,253	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	50,730	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,453,691	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,524,340	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,726,334	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,250,674	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,704,365	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,677,787				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)	2,677,787	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,382,152	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-1 | Date/Time Prepared: 10/19/2017 9:35 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		4,537,321		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,859,534				2.00
3.00	Total (sum of line 1 and line 2)		2,677,787		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		2,677,787		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,677,787		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/19/2017 9:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,021,905		2,021,905	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)	2,021,905		2,021,905	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,021,905		2,021,905	17.00
18.00	Ancillary services	4,183,511	24,714,510	28,898,021	18.00
19.00	Outpatient services	32,021	3,059,327	3,091,348	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN FEES	0	1,207,525	1,207,525	27.00
27.01	PRO FEES	170,376	1,273,017	1,443,393	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,407,813	30,254,379	36,662,192	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,397,095		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)		20,397,095		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1300 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-3 | Date/Time Prepared: 10/19/2017 9:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,662,192	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,937,788	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,724,404	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,397,095	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,672,691	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	383,459	24.00
24.01	GRANTS/FOUNDATION	429,698	24.01
25.00	Total other income (sum of lines 6-24)	813,157	25.00
26.00	Total (line 5 plus line 25)	-1,859,534	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)	-1,859,534	29.00