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: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/31/2018 11:21 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2018 Time: 11:21 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (15-1318) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

VICE PRESIDENT REVENUE MANAGEMENT
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	774,206	-1,707,679	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	65,403	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	839,609	-1,707,679	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:18 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:			1.00
2.00	City: PERU	State: IN	Zip Code: 46970	County: MIAMI	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	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	15Z318	99915		12/01/2003	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:18 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)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	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(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 11:18 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 11:18 am

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:18 am

		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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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.	Y	Y	Y	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	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.	N			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:	15,197	21,052	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 11:18 am

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.		Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD		PO Box:		142.00
143.00	City: FRANKLIN		State: TN	Zip Code: 37067	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.			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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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)	09/01/2017	11/29/2017	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2018 11:18 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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/25/2018	Y	05/25/2018	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 11:18 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.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 11:18 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2018 11:18 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	21	7,665	71,952.00	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)		21	7,665	71,952.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	13,008.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	84,960.00	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)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 11:18 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)	1,556	47	2,976			1.00
2.00	HMO and other (see instructions)	324	504				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	104	0	106			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,660	47	3,082			7.00
8.00	INTENSIVE CARE UNIT	331	17	594			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		18	335			13.00
14.00	Total (see instructions)	1,991	82	4,011	0.00	199.05	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	22			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	199.05	27.00
28.00	Observation Bed Days		0	643			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 11:18 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	543	233	1,113	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	543	233	1,113	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 11:18 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,053,992	0	13,053,992	414,023.00	31.53	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		260,458	-615	259,843	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		0	0	0			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	112,315	0	112,315	3,939.00	28.51	26.00
27.00	Administrative & General	5.00	1,661,779	22,609	1,684,388	0.00	0.00	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 11:18 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	276,329	615	276,944	10,538.00	26.28	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	281,480	0	281,480	22,687.00	12.41	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	201,885	-38,254	163,631	10,453.00	15.65	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	38,254	38,254	2,801.00	13.66	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	435,299	-90,600	344,699	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	83,570	0	83,570	5,331.00	15.68	39.00
40.00	Pharmacy	15.00	478,025	0	478,025	10,790.00	44.30	40.00
41.00	Medical Records & Medical Records Library	16.00	98,541	0	98,541	6,251.00	15.76	41.00
42.00	Social Service	17.00	0	67,991	67,991	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2018 11:18 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		13,053,992	0	13,053,992	414,023.00	31.53	1.00
2.00	Excluded area salaries (see instructions)		260,458	-615	259,843	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12,793,534	615	12,794,149	414,023.00	30.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		12,793,534	615	12,794,149	414,023.00	30.90	6.00
7.00	Total overhead cost (see instructions)		3,629,223	615	3,629,838	72,790.00	49.87	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2018 11:18 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	169,936	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,539,217	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	8,611	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,408	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	208	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7,253	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	317,143	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	626,854	17.00
18.00	Medicare Taxes - Employers Portion Only	146,603	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	32,023	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,857,256	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS	0	25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/31/2018 11:18 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)	0.166654	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,384,629	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,242,297	5.00
6.00	Medicaid charges	37,421,527	6.00
7.00	Medicaid cost (line 1 times line 6)	6,236,447	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)	0	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)	150,989	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	800,719	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	133,443	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)	0	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)	209,561	26,912	236,473	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	34,924	26,912	61,836	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)	34,924	26,912	61,836	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		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)	4,971,174	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	689,160	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,060,247	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,910,927	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,022,859	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,084,695	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,084,695	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 11:18 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	CAP REL COSTS-BLDG & FIXT		942,891	942,891	417,206	1,360,097	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,451,540	1,451,540	396,049	1,847,589	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	112,315	102,027	214,342	1,150,574	1,364,916	4.00
5.01	00570	ADMITTING	0	0	0	852,950	852,950	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	1,661,779	6,889,699	8,551,478	-2,323,787	6,227,691	5.02
7.00	00700	OPERATION OF PLANT	276,329	1,447,518	1,723,847	99,035	1,822,882	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	81,805	81,805	-27	81,778	8.00
9.00	00900	HOUSEKEEPING	281,480	99,305	380,785	-139	380,646	9.00
10.00	01000	DIETARY	201,885	157,190	359,075	-74,503	284,572	10.00
11.00	01100	CAFETERIA	0	0	0	72,880	72,880	11.00
13.00	01300	NURSING ADMINISTRATION	435,299	54,507	489,806	-234,965	254,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,570	235,061	318,631	-105,854	212,777	14.00
15.00	01500	PHARMACY	478,025	1,153,971	1,631,996	-939,765	692,231	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,541	240,787	339,328	-5,906	333,422	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	74,264	74,264	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,688,165	1,025,806	2,713,971	-136,745	2,577,226	30.00
31.00	03100	INTENSIVE CARE UNIT	373,143	113,226	486,369	-1,756	484,613	31.00
43.00	04300	NURSERY	0	495	495	120,288	120,783	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	460,221	1,473,274	1,933,495	-622,088	1,311,407	50.00
51.00	05100	RECOVERY ROOM	265,543	69,929	335,472	-1,749	333,723	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	89,779	89,779	0	89,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,757	623,169	1,501,926	-101,964	1,399,962	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	757,289	867,538	1,624,827	-64,973	1,559,854	60.00
65.00	06500	RESPIRATORY THERAPY	424,660	103,547	528,207	-20,602	507,605	65.00
66.00	06600	PHYSICAL THERAPY	2,275	460,591	462,866	-1,090	461,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	129,366	129,366	0	129,366	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,522	21,522	0	21,522	68.00
69.00	06900	ELECTROCARDIOLOGY	124,274	25,908	150,182	-3,720	146,462	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	68,873	68,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	592,119	592,119	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	857,631	857,631	73.00
76.00	03610	SLEEP LAB	66,173	22,188	88,361	-998	87,363	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	279,888	43,483	323,371	-3,300	320,071	90.00
91.00	09100	EMERGENCY	3,843,923	581,211	4,425,134	-9,013	4,416,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	259,672	149,753	409,425	-32,807	376,618	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,053,206	18,657,086	31,710,292	16,118	31,726,410	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	786	15,512	16,298	-16,118	180	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	43	43	0	43	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,053,992	18,672,641	31,726,633	0	31,726,633	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-309,107	1,050,990		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	274,073	2,121,662		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,097	1,362,819		4.00
5.01	00570	ADMITTING	-184,043	668,907		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-448,576	5,779,115		5.02
7.00	00700	OPERATION OF PLANT	-23,522	1,799,360		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	81,778		8.00
9.00	00900	HOUSEKEEPING	0	380,646		9.00
10.00	01000	DIETARY	0	284,572		10.00
11.00	01100	CAFETERIA	-62,986	9,894		11.00
13.00	01300	NURSING ADMINISTRATION	-7,517	247,324		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	212,777		14.00
15.00	01500	PHARMACY	0	692,231		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,599	321,823		16.00
17.00	01700	SOCIAL SERVICE	0	74,264		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-296,613	2,280,613		30.00
31.00	03100	INTENSIVE CARE UNIT	0	484,613		31.00
43.00	04300	NURSERY	0	120,783		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-421,475	889,932		50.00
51.00	05100	RECOVERY ROOM	0	333,723		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-89,779	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,399,962		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,559,854		60.00
65.00	06500	RESPIRATORY THERAPY	0	507,605		65.00
66.00	06600	PHYSICAL THERAPY	0	461,776		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	129,366		67.00
68.00	06800	SPEECH PATHOLOGY	0	21,522		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,882	143,580		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	68,873		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	592,119		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	857,631		73.00
76.00	03610	SLEEP LAB	0	87,363		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	320,071		90.00
91.00	09100	EMERGENCY	-148,305	4,267,816		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	376,618		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,734,428	29,991,982		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	180		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	43		194.02
194.03	07953	FREE MEALS	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,734,428	29,992,205		200.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 11:18 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,152,197		1.00
	TOTALS		0	1,152,197		
	B - RECLASS OXYGEN COSTS					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	C - RECLASS RENT AND LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	367,665		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	TOTALS		0	367,665		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59,054		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	358,152		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,384		3.00
	TOTALS		0	445,590		
	F - RECLASS CNO COSTS					
1.00	NURSING ADMINISTRATION	13.00	159,157	0		1.00
	TOTALS		159,157	0		
	G - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	68,873		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	592,119		2.00
	TOTALS		0	660,992		
	H - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	857,631		1.00
	TOTALS		0	857,631		
	I - RECLASS LABOR AND DELIVERY					
1.00	NURSERY	43.00	102,048	18,240		1.00
	TOTALS		102,048	18,240		
	J - RECLASS NURSING ADMIN COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	181,766	135,630		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	67,991	6,273		2.00
	TOTALS		249,757	141,903		
	K - RECLASS MISC DEPARTMENTS					
1.00	ADMITTING	5.01	459,301	393,649		1.00
	TOTALS		459,301	393,649		
	L - RECLASS OTHER RADIOLOGY					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	M - RECLASS DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	38,254	34,626		1.00
	TOTALS		38,254	34,626		
	N - RECLASS PHYSICIAN PRACTICES COSTS					
1.00	OPERATION OF PLANT	7.00	615	15,394		1.00
	TOTALS		615	15,394		
	P - CASE MANAGEMENT					
1.00	SOCIAL SERVICE	17.00	67,991	6,273		1.00
	TOTALS		67,991	6,273		
	Q - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	96,464		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 11:18 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	TOTALS		0	96,464		
500.00	Grand Total: Increases		1,077,123	4,190,624		500.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 11:18 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	1,152,197	0		1.00
	TOTALS		0	1,152,197			
	B - RECLASS OXYGEN COSTS						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	C - RECLASS RENT AND LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,623	10		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	20,677	0		2.00
3.00	OPERATION OF PLANT	7.00	0	13,438	0		3.00
4.00	DIETARY	10.00	0	1,623	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,462	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,052	0		6.00
7.00	PHARMACY	15.00	0	81,924	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,228	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	11,810	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	839	0		10.00
11.00	OPERATING ROOM	50.00	0	30,919	0		11.00
12.00	RECOVERY ROOM	51.00	0	1,623	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	88,301	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,623	0		14.00
15.00	LABORATORY	60.00	0	62,622	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	17,251	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	935	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	1,623	0		18.00
19.00	SLEEP LAB	76.00	0	998	0		19.00
20.00	CLINIC	90.00	0	3,300	0		20.00
21.00	EMERGENCY	91.00	0	2,346	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	4,339	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	109	0		23.00
	TOTALS		0	367,665			
	D - RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	445,590	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	445,590			
	F - RECLASS CNO COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	159,157	0	0		1.00
	TOTALS		159,157	0			
	G - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	93,505	0		1.00
2.00	OPERATING ROOM	50.00	0	567,487	0		2.00
	TOTALS		0	660,992			
	H - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	857,631	0		1.00
	TOTALS		0	857,631			
	I - RECLASS LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	102,048	18,240	0		1.00
	TOTALS		102,048	18,240			
	J - RECLASS NURSING ADMIN COSTS						
1.00	NURSING ADMINISTRATION	13.00	249,757	141,903	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		249,757	141,903			
	K - RECLASS MISC DEPARTMENTS						
1.00	ADMINISTRATIVE AND GENERAL	5.02	459,301	393,649	0		1.00
	TOTALS		459,301	393,649			
	L - RECLASS OTHER RADIOLOGY						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	M - RECLASS DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	38,254	34,626	0		1.00
	TOTALS		38,254	34,626			
	N - RECLASS PHYSICIAN PRACTICES COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	615	15,394	0		1.00
	TOTALS		615	15,394			
	P - CASE MANAGEMENT						
1.00	MEDICAL RECORDS & LIBRARY	16.00	67,991	6,273	0		1.00
	TOTALS		67,991	6,273			
	Q - REPAIRS AND MAINTENANCE						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	10,612	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	27	0		2.00
3.00	HOUSEKEEPING	9.00	0	139	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	297	0		4.00
5.00	PHARMACY	15.00	0	210	0		5.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 11:18 am

	Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	678	0			6.00
7.00	ADULTS & PEDIATRICS	30.00	0	4,647	0			7.00
8.00	INTENSIVE CARE UNIT	31.00	0	917	0			8.00
9.00	OPERATING ROOM	50.00	0	23,682	0			9.00
10.00	RECOVERY ROOM	51.00	0	126	0			10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,665	0			11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,375	0			12.00
13.00	LABORATORY	60.00	0	2,351	0			13.00
14.00	RESPIRATORY THERAPY	65.00	0	3,351	0			14.00
15.00	PHYSICAL THERAPY	66.00	0	155	0			15.00
16.00	ELECTROCARDIOLOGY	69.00	0	2,097	0			16.00
17.00	EMERGENCY	91.00	0	6,667	0			17.00
18.00	AMBULANCE SERVICES	95.00	0	28,468	0			18.00
	TOTALS		0	96,464				
500.00	Grand Total: Decreases		1,077,123	4,190,624				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I Date/Time Prepared: 5/31/2018 11:18 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	193,225	0	0	0	0	1.00
2.00	Land Improvements	976,669	38,015	0	38,015	0	2.00
3.00	Buildings and Fixtures	26,135,998	1,516,677	0	1,516,677	335,713	3.00
4.00	Building Improvements	28,020,100	5,951,301	0	5,951,301	592,177	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	4,748,489	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,074,481	7,505,993	0	7,505,993	927,890	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	60,074,481	7,505,993	0	7,505,993	927,890	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	193,225	0	1.00
2.00	Land Improvements	1,014,684	0	2.00
3.00	Buildings and Fixtures	27,316,962	0	3.00
4.00	Building Improvements	33,379,224	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	4,748,489	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,652,584	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	66,652,584	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2018 11:18 am

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

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	942,891	942,891		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,451,540	1,451,540		2.00
3.00	Total (sum of lines 1-2)	2,394,431	2,394,431		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2018 11:18 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	53	0	53	0.530000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47	0	47	0.470000	0	2.00
3.00	Total (sum of lines 1-2)	100	0	100	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	-332,514	14,980	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	178,331	461,048	2.00
3.00	Total (sum of lines 1-2)	0	0	0	-154,183	476,028	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,427	59,054	358,152	942,891	1,050,990	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,359	28,384	0	1,451,540	2,121,662	2.00
3.00	Total (sum of lines 1-2)	10,786	87,438	358,152	2,394,431	3,172,652	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 11:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-29,254	ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,576	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-951,874			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	-197,448			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-62,986	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-11,599	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,542	ADMINISTRATIVE AND GENERAL	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-353,501	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	171,051	CAP REL COSTS-MVBLE EQUIP	2.00	9	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)	A	-7,180	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 11:18 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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	NON-ALLOWABLE MARKETING	A	-211,534	ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	POB DEPRECIATION	A	20,987	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
33.03	POB DEPRECIATION	A	15,864	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
35.00	TRAINING REVENUE	B	-7,517	NURSING ADMINISTRATION	13.00	0	35.00
36.00	FITNESS REVENUE	B	-240	ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	OTHER MISC REVENUE - HOSPITAL	B	-6,996	ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	PATIENT PHONES BENEFITS COST	A	-2,097	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
40.00	PATIENT PHONES DEPRECIATION COST	A	-5,008	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
41.00	PATIENT TV SERVICE COST	A	-23,522	OPERATION OF PLANT	7.00	0	41.00
42.00	NON-ALLOWABLE LOBBYING EXPENSE	A	-2,344	ADMINISTRATIVE AND GENERAL	5.02	0	42.00
43.00	MARKETING EXPENSE	A	-17,104	ADMINISTRATIVE AND GENERAL	5.02	0	43.00
44.00	PENALTIES	A	-32	ADMINISTRATIVE AND GENERAL	5.02	0	44.00
44.01	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-2,344	ADMINISTRATIVE AND GENERAL	5.02	9	44.01
45.00	CHARITABLE CONTRIBUTIONS	A	-4,760	ADMINISTRATIVE AND GENERAL	5.02	0	45.00
45.01	PHYSICIAN RECRUITING	A	-35,844	ADMINISTRATIVE AND GENERAL	5.02	0	45.01
45.05	LEGAL FEES	A	-2,911	ADMINISTRATIVE AND GENERAL	5.02	0	45.05
45.07	MEALS AND ENTERTAINMENT	A	-1,117	ADMINISTRATIVE AND GENERAL	5.02	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,734,428				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 11:18 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	8,427	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	2,359	0	2.00
3.00	5.02	ADMINISTRATIVE AND GENERAL	PASI OPERATING COSTS	124,089	0	3.00
3.02	5.02	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	442,580	0	3.02
3.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING AND F	14,980	0	3.04
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	93,383	0	4.00
4.01	5.02	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	865,918	0	4.01
4.02	5.02	ADMINISTRATIVE AND GENERAL	MALPRACTICE ALLOCATIONS (PER	21,052	134,526	4.02
4.05	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (P	102,149	102,149	4.05
4.06	5.02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	284,571	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	401K FEES	0	6,816	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	19,775	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD FEES	0	959,686	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	PPSI FEES	0	24,094	4.10
4.11	5.01	ADMITTING	PASI COLLECTION FEES	0	153,415	4.11
4.12	5.02	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	156,725	4.12
4.13	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	30,628	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,674,937	1,872,385	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	B		0.00	HOSPITAL LAUNDRY SERVICE	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 11:18 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	8,427	11		1.00
2.00	2,359	11		2.00
3.00	124,089	0		3.00
3.02	442,580	0		3.02
3.04	14,980	10		3.04
4.00	93,383	10		4.00
4.01	865,918	0		4.01
4.02	-113,474	0		4.02
4.05	0	0		4.05
4.06	-284,571	0		4.06
4.07	-6,816	0		4.07
4.08	-19,775	0		4.08
4.09	-959,686	0		4.09
4.10	-24,094	0		4.10
4.11	-153,415	0		4.11
4.12	-156,725	0		4.12
4.13	-30,628	0		4.13
5.00	-197,448			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY SERVICE		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2018 11:18 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	30.00	ADULTS & PEDIATRICS	289,433	289,433	0	0	0	1.00
2.00	50.00	OPERATING ROOM	421,475	421,475	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	89,779	89,779	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	2,882	2,882	0	0	0	4.00
5.00	91.00	EMERGENCY	2,392,287	148,305	2,243,982	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			3,195,856	951,874	2,243,982		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	289,433		1.00
2.00	50.00	OPERATING ROOM	0	0	0	421,475		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	89,779		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,882		4.00
5.00	91.00	EMERGENCY	0	0	0	148,305		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	951,874		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 11:18 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					5.19	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	4,696.84	4,095.50	3,588.45	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.00	50.50	17.50	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)	35.00	35.00	25.25			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)					328,779	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					206,823	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					535,602	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					62,798	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)					598,400	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)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					598,400	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)					0	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)					0	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)					0	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)					0	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 11:18 am

Physical Therapy — 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)	70.00	50.50	17.50	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)	598,400		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		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)	598,400		63.00
64.00	Total cost of outside supplier services (from your records)	0		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	0		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	0		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: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2018 11:18 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		0	1.00
2.00	Line 1 multiplied by 15 hours per week		0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	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	1,278.00	854.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.00	50.50	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)	35.00	35.00	25.25			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)	89,460	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	43,127	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	132,587	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)	132,587	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)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	132,587	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)	0	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)	0	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)	0	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)	0	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 11:18 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)	70.00	50.50	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)	132,587	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	132,587	63.00
64.00	Total cost of outside supplier services (from your records)	0	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	0	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	0	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 11:18 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					5.19	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	222.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.99	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)	35.00	35.00	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)					15,538	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)					15,538	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)					15,538	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)					69.99	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,592	22.00
23.00	Total salary equivalency (see instructions)					54,592	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)					0	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)					0	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)					0	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)					0	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 11:18 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)	69.99	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)	54,592		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		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)	54,592		63.00
64.00	Total cost of outside supplier services (from your records)	0		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	0		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	0		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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,050,990	1,050,990				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,121,662		2,121,662			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,362,819	7,417	15,034	1,385,270		4.00
5.01	00570	ADMITTING	668,907	11,285	22,874	49,163	752,229	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	5,779,115	53,508	108,461	131,132	0	5.02
7.00	00700	OPERATION OF PLANT	1,799,360	311,009	630,424	29,644	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,778	12,210	24,751	0	0	8.00
9.00	00900	HOUSEKEEPING	380,646	10,109	20,491	30,129	0	9.00
10.00	01000	DIETARY	284,572	25,522	51,734	17,515	0	10.00
11.00	01100	CAFETERIA	9,894	16,392	33,227	4,095	0	11.00
13.00	01300	NURSING ADMINISTRATION	247,324	4,767	9,663	36,896	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	212,777	25,017	50,709	8,945	0	14.00
15.00	01500	PHARMACY	692,231	11,678	23,672	51,167	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	321,823	21,106	42,782	10,548	0	16.00
17.00	01700	SOCIAL SERVICE	74,264	0	0	7,278	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,280,613	175,192	355,115	169,776	34,131	30.00
31.00	03100	INTENSIVE CARE UNIT	484,613	20,303	41,154	39,941	6,180	31.00
43.00	04300	NURSERY	120,783	4,017	8,142	10,923	1,636	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	889,932	80,488	163,149	49,262	88,912	50.00
51.00	05100	RECOVERY ROOM	333,723	5,794	11,744	28,423	15,307	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,399,962	56,610	114,748	94,061	162,306	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,559,854	22,633	45,878	81,059	107,034	60.00
65.00	06500	RESPIRATORY THERAPY	507,605	9,715	19,693	45,455	10,062	65.00
66.00	06600	PHYSICAL THERAPY	461,776	13,333	27,026	244	12,061	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,366	4,363	8,843	0	4,960	67.00
68.00	06800	SPEECH PATHOLOGY	21,522	176	356	0	452	68.00
69.00	06900	ELECTROCARDIOLOGY	143,580	6,592	13,362	13,302	25,901	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,873	0	0	0	23,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	592,119	0	0	0	17,087	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,631	0	0	0	110,615	73.00
76.00	03610	SLEEP LAB	87,363	9,412	19,078	7,083	3,078	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	320,071	6,119	12,402	29,959	2,977	90.00
91.00	09100	EMERGENCY	4,267,816	38,988	79,029	411,457	97,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	376,618	15,701	31,825	27,795	28,903	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,991,982	979,456	1,985,366	1,385,252	752,229	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,294	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	180	67,240	136,296	18	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	43	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,992,205	1,050,990	2,121,662	1,385,270	752,229	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	6,072,216	6,072,216				5.02
7.00	00700	OPERATION OF PLANT	2,770,437	703,289	3,473,726			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,739	30,142	63,518	212,399		8.00
9.00	00900	HOUSEKEEPING	441,375	112,045	52,586	0	606,006	9.00
10.00	01000	DIETARY	379,343	96,298	132,766	0	23,963	10.00
11.00	01100	CAFETERIA	63,608	16,147	85,272	0	15,391	11.00
13.00	01300	NURSING ADMINISTRATION	298,650	75,814	24,798	0	4,476	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297,448	75,509	130,137	0	23,488	14.00
15.00	01500	PHARMACY	778,748	197,689	60,751	0	10,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	396,259	100,592	109,794	0	19,816	16.00
17.00	01700	SOCIAL SERVICE	81,542	20,700	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,014,827	765,329	911,349	161,869	164,485	30.00
31.00	03100	INTENSIVE CARE UNIT	592,191	150,331	105,615	32,309	19,062	31.00
43.00	04300	NURSERY	145,501	36,936	20,896	18,221	3,771	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,271,743	322,838	418,696	0	75,569	50.00
51.00	05100	RECOVERY ROOM	394,991	100,270	30,140	0	5,440	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,827,687	463,967	294,482	0	53,150	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,816,458	461,117	117,737	0	21,250	60.00
65.00	06500	RESPIRATORY THERAPY	592,530	150,417	50,538	0	9,121	65.00
66.00	06600	PHYSICAL THERAPY	514,440	130,593	69,358	0	12,518	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,532	37,452	22,695	0	4,096	67.00
68.00	06800	SPEECH PATHOLOGY	22,506	5,713	913	0	165	68.00
69.00	06900	ELECTROCARDIOLOGY	202,737	51,466	34,292	0	6,189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,410	23,459	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	609,206	154,650	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	968,246	245,794	0	0	0	73.00
76.00	03610	SLEEP LAB	126,014	31,989	48,960	0	8,837	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	371,528	94,314	31,828	0	5,745	90.00
91.00	09100	EMERGENCY	4,894,380	1,242,472	202,816	0	36,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	480,842	122,064	81,674	0	14,741	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,784,134	6,019,396	3,101,611	212,399	538,844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,294	1,090	22,335	0	4,031	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	203,734	51,719	349,780	0	63,131	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	43	11	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,992,205	6,072,216	3,473,726	212,399	606,006	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	632,370					10.00
11.00	01100	CAFETERIA	0	180,418				11.00
13.00	01300	NURSING ADMINISTRATION	0	8,016	411,754			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,177	0	529,759		14.00
15.00	01500	PHARMACY	0	6,440	0	15,624	1,070,217	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,735	0	734	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	481,930	34,743	74,145	28,127	0	30.00
31.00	03100	INTENSIVE CARE UNIT	96,191	6,204	16,503	3,264	0	31.00
43.00	04300	NURSERY	54,249	0	5,873	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,063	25,169	107,054	0	50.00
51.00	05100	RECOVERY ROOM	0	4,455	13,826	5,448	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,543	47,063	26,722	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	21,864	37,711	97,996	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,127	0	9,166	0	65.00
66.00	06600	PHYSICAL THERAPY	0	87	0	2,350	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	2,494	0	1,461	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	51,088	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	140,393	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,070,217	73.00
76.00	03610	SLEEP LAB	0	1,290	0	1,210	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,790	0	6,501	0	90.00
91.00	09100	EMERGENCY	0	38,652	191,464	17,629	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,713	0	14,886	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	632,370	180,393	411,754	529,653	1,070,217	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25	0	106	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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 through 201)	632,370	180,418	411,754	529,759	1,070,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	630,930					16.00
17.00	01700	SOCIAL SERVICE	0	102,242				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,629	77,919	5,743,352	0	5,743,352	30.00
31.00	03100	INTENSIVE CARE UNIT	5,184	15,552	1,042,406	0	1,042,406	31.00
43.00	04300	NURSERY	1,372	8,771	295,590	0	295,590	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,578	0	2,305,710	0	2,305,710	50.00
51.00	05100	RECOVERY ROOM	12,839	0	567,409	0	567,409	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,111	0	2,868,725	0	2,868,725	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	89,778	0	2,663,911	0	2,663,911	60.00
65.00	06500	RESPIRATORY THERAPY	8,440	0	828,339	0	828,339	65.00
66.00	06600	PHYSICAL THERAPY	10,117	0	739,463	0	739,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,160	0	215,935	0	215,935	67.00
68.00	06800	SPEECH PATHOLOGY	379	0	29,676	0	29,676	68.00
69.00	06900	ELECTROCARDIOLOGY	21,726	0	320,365	0	320,365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,742	0	186,699	0	186,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,333	0	918,582	0	918,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92,782	0	2,377,039	0	2,377,039	73.00
76.00	03610	SLEEP LAB	2,582	0	220,882	0	220,882	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,497	0	517,203	0	517,203	90.00
91.00	09100	EMERGENCY	81,438	0	6,705,457	0	6,705,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	24,243	0	745,163	0	745,163	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	630,930	102,242	29,291,906	0	29,291,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	31,750	0	31,750	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	668,495	0	668,495	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	54	0	54	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	630,930	102,242	29,992,205	0	29,992,205	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,417	15,034	22,451	22,451	4.00
5.01	00570	ADMITTING	0	11,285	22,874	34,159	797	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	53,508	108,461	161,969	2,126	5.02
7.00	00700	OPERATION OF PLANT	0	311,009	630,424	941,433	480	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,210	24,751	36,961	0	8.00
9.00	00900	HOUSEKEEPING	0	10,109	20,491	30,600	488	9.00
10.00	01000	DIETARY	0	25,522	51,734	77,256	284	10.00
11.00	01100	CAFETERIA	0	16,392	33,227	49,619	66	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,767	9,663	14,430	598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,017	50,709	75,726	145	14.00
15.00	01500	PHARMACY	0	11,678	23,672	35,350	829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,106	42,782	63,888	171	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	118	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	175,192	355,115	530,307	2,752	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,303	41,154	61,457	647	31.00
43.00	04300	NURSERY	0	4,017	8,142	12,159	177	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	80,488	163,149	243,637	798	50.00
51.00	05100	RECOVERY ROOM	0	5,794	11,744	17,538	461	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,610	114,748	171,358	1,525	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	22,633	45,878	68,511	1,314	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,715	19,693	29,408	737	65.00
66.00	06600	PHYSICAL THERAPY	0	13,333	27,026	40,359	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,363	8,843	13,206	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	176	356	532	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,592	13,362	19,954	216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	9,412	19,078	28,490	115	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,119	12,402	18,521	486	90.00
91.00	09100	EMERGENCY	0	38,988	79,029	118,017	6,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,701	31,825	47,526	451	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	979,456	1,985,366	2,964,822	22,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,294	0	4,294	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	67,240	136,296	203,536	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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 through 201)	0	1,050,990	2,121,662	3,172,652	22,451	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	ADMITTING	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	34,956					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	164,095				5.02
7.00	00700	OPERATION OF PLANT	0	19,005	960,918			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	815	17,571	55,347		8.00
9.00	00900	HOUSEKEEPING	0	3,028	14,547	0	48,663	9.00
10.00	01000	DIETARY	0	2,602	36,726	0	1,924	10.00
11.00	01100	CAFETERIA	0	436	23,588	0	1,236	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,049	6,860	0	359	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,040	35,999	0	1,886	14.00
15.00	01500	PHARMACY	0	5,342	16,805	0	880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,718	30,372	0	1,591	16.00
17.00	01700	SOCIAL SERVICE	0	559	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,587	20,682	252,099	42,180	13,211	30.00
31.00	03100	INTENSIVE CARE UNIT	287	4,062	29,216	8,419	1,531	31.00
43.00	04300	NURSERY	76	998	5,780	4,748	303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,134	8,724	115,822	0	6,068	50.00
51.00	05100	RECOVERY ROOM	712	2,710	8,338	0	437	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,528	12,538	81,461	0	4,268	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,977	12,461	32,569	0	1,706	60.00
65.00	06500	RESPIRATORY THERAPY	468	4,065	13,980	0	732	65.00
66.00	06600	PHYSICAL THERAPY	561	3,529	19,186	0	1,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	231	1,012	6,278	0	329	67.00
68.00	06800	SPEECH PATHOLOGY	21	154	253	0	13	68.00
69.00	06900	ELECTROCARDIOLOGY	1,204	1,391	9,486	0	497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,094	634	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	794	4,179	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,143	6,642	0	0	0	73.00
76.00	03610	SLEEP LAB	143	864	13,544	0	710	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	138	2,549	8,805	0	461	90.00
91.00	09100	EMERGENCY	4,514	33,581	56,104	0	2,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,344	3,299	22,593	0	1,184	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,956	162,668	857,982	55,347	43,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29	6,178	0	324	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,398	96,758	0	5,069	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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 through 201)	34,956	164,095	960,918	55,347	48,663	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	118,792					10.00
11.00	01100	CAFETERIA	0	74,945				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,330	27,626			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,320	0	117,116		14.00
15.00	01500	PHARMACY	0	2,675	0	3,454	65,335	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,551	0	162	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,531	14,432	4,974	6,218	0	30.00
31.00	03100	INTENSIVE CARE UNIT	18,070	2,577	1,107	722	0	31.00
43.00	04300	NURSERY	10,191	0	394	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,180	1,689	23,667	0	50.00
51.00	05100	RECOVERY ROOM	0	1,850	928	1,204	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,118	3,157	5,908	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	9,082	2,530	21,664	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,376	0	2,026	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36	0	519	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	1,036	0	323	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,294	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,039	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	65,335	73.00
76.00	03610	SLEEP LAB	0	536	0	268	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,990	0	1,437	0	90.00
91.00	09100	EMERGENCY	0	16,057	12,847	3,897	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,789	0	3,291	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,792	74,935	27,626	117,093	65,335	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10	0	23	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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 through 201)	118,792	74,945	27,626	117,116	65,335	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100,453					16.00
17.00	01700	SOCIAL SERVICE	0	677				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,561	516	984,050	0	984,050	30.00
31.00	03100	INTENSIVE CARE UNIT	826	103	129,024	0	129,024	31.00
43.00	04300	NURSERY	219	58	35,103	0	35,103	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,883	0	420,602	0	420,602	50.00
51.00	05100	RECOVERY ROOM	2,046	0	36,224	0	36,224	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,610	0	317,471	0	317,471	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	14,305	0	169,119	0	169,119	60.00
65.00	06500	RESPIRATORY THERAPY	1,345	0	56,137	0	56,137	65.00
66.00	06600	PHYSICAL THERAPY	1,612	0	66,811	0	66,811	66.00
67.00	06700	OCCUPATIONAL THERAPY	663	0	21,719	0	21,719	67.00
68.00	06800	SPEECH PATHOLOGY	60	0	1,033	0	1,033	68.00
69.00	06900	ELECTROCARDIOLOGY	3,462	0	37,569	0	37,569	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,146	0	16,168	0	16,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,284	0	38,296	0	38,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,783	0	91,903	0	91,903	73.00
76.00	03610	SLEEP LAB	411	0	45,081	0	45,081	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	398	0	34,785	0	34,785	90.00
91.00	09100	EMERGENCY	12,976	0	267,598	0	267,598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,863	0	86,340	0	86,340	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,453	677	2,855,033	0	2,855,033	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	10,825	0	10,825	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	306,794	0	306,794	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	100,453	677	3,172,652	0	3,172,652	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEE T)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEE T)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHAR GES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	197,538					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		196,731				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,394	1,394	12,941,677			4.00
5.01	00570	ADMITTING	2,121	2,121	459,301	175,765,142		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	10,057	10,057	1,225,087	0	-6,072,216	5.02
7.00	00700	OPERATION OF PLANT	58,456	58,456	276,944	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,295	2,295	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,900	1,900	281,480	0	0	9.00
10.00	01000	DIETARY	4,797	4,797	163,631	0	0	10.00
11.00	01100	CAFETERIA	3,081	3,081	38,254	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	896	896	344,699	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,702	4,702	83,570	0	0	14.00
15.00	01500	PHARMACY	2,195	2,195	478,025	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,967	3,967	98,541	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	67,991	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,928	32,928	1,586,117	7,974,563	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,816	3,816	373,143	1,443,892	0	31.00
43.00	04300	NURSERY	755	755	102,048	382,225	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,128	15,128	460,221	20,773,885	0	50.00
51.00	05100	RECOVERY ROOM	1,089	1,089	265,543	3,576,286	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,640	10,640	878,757	37,932,740	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,254	4,254	757,289	25,007,892	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,826	1,826	424,660	2,351,036	0	65.00
66.00	06600	PHYSICAL THERAPY	2,506	2,506	2,275	2,818,046	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	820	820	0	1,158,770	0	67.00
68.00	06800	SPEECH PATHOLOGY	33	33	0	105,532	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,239	1,239	124,274	6,051,685	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,499,198	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,992,398	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,844,627	0	73.00
76.00	03610	SLEEP LAB	1,769	1,769	66,173	719,259	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,150	1,150	279,888	695,456	0	90.00
91.00	09100	EMERGENCY	7,328	7,328	3,843,923	22,684,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,951	2,951	259,672	6,753,045	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,093	184,093	12,941,506	175,765,142	-6,072,216	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,638	12,638	171	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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)	1,050,990	2,121,662	1,385,270	752,229		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.320445	10.784584	0.107039	0.004280		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			22,451	34,956		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001735	0.000199		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEE T)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEE T)	DIETARY (TOTAL PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	23,919,989					5.02
7.00	00700	OPERATION OF PLANT	2,770,437	125,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,739	2,295	3,905			8.00
9.00	00900	HOUSEKEEPING	441,375	1,900	0	121,315		9.00
10.00	01000	DIETARY	379,343	4,797	0	4,797	3,905	10.00
11.00	01100	CAFETERIA	63,608	3,081	0	3,081	0	11.00
13.00	01300	NURSING ADMINISTRATION	298,650	896	0	896	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297,448	4,702	0	4,702	0	14.00
15.00	01500	PHARMACY	778,748	2,195	0	2,195	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	396,259	3,967	0	3,967	0	16.00
17.00	01700	SOCIAL SERVICE	81,542	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,014,827	32,928	2,976	32,928	2,976	30.00
31.00	03100	INTENSIVE CARE UNIT	592,191	3,816	594	3,816	594	31.00
43.00	04300	NURSERY	145,501	755	335	755	335	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,271,743	15,128	0	15,128	0	50.00
51.00	05100	RECOVERY ROOM	394,991	1,089	0	1,089	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,827,687	10,640	0	10,640	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,816,458	4,254	0	4,254	0	60.00
65.00	06500	RESPIRATORY THERAPY	592,530	1,826	0	1,826	0	65.00
66.00	06600	PHYSICAL THERAPY	514,440	2,506	0	2,506	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,532	820	0	820	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,506	33	0	33	0	68.00
69.00	06900	ELECTROCARDIOLOGY	202,737	1,239	0	1,239	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,410	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	609,206	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	968,246	0	0	0	0	73.00
76.00	03610	SLEEP LAB	126,014	1,769	0	1,769	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	371,528	1,150	0	1,150	0	90.00
91.00	09100	EMERGENCY	4,894,380	7,328	0	7,328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	480,842	2,951	0	2,951	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,711,918	112,065	3,905	107,870	3,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,294	807	0	807	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	203,734	12,638	0	12,638	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	43	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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)	6,072,216	3,473,726	212,399	606,006	632,370	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.253855	27.676886	54.391549	4.995310	161.938540	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	164,095	960,918	55,347	48,663	118,792	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006860	7.656107	14.173367	0.401129	30.420487	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ U)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	14,540					11.00
13.00	01300	NURSING ADMINISTRATION	646	7,154,505				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	256	0	2,123,880			14.00
15.00	01500	PHARMACY	519	0	62,640	848,922		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301	0	2,941	0	175,765,142	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,800	1,288,311	112,766	0	7,974,563	30.00
31.00	03100	INTENSIVE CARE UNIT	500	286,750	13,086	0	1,443,892	31.00
43.00	04300	NURSERY	0	102,048	0	0	382,225	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	811	437,325	429,195	0	20,773,885	50.00
51.00	05100	RECOVERY ROOM	359	240,242	21,840	0	3,576,286	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,575	817,754	107,134	0	37,932,740	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,762	655,250	392,879	0	25,007,892	60.00
65.00	06500	RESPIRATORY THERAPY	655	0	36,748	0	2,351,036	65.00
66.00	06600	PHYSICAL THERAPY	7	0	9,420	0	2,818,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,158,770	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	105,532	68.00
69.00	06900	ELECTROCARDIOLOGY	201	0	5,859	0	6,051,685	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	204,820	0	5,499,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	562,855	0	3,992,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	848,922	25,844,627	73.00
76.00	03610	SLEEP LAB	104	0	4,852	0	719,259	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	386	0	26,063	0	695,456	90.00
91.00	09100	EMERGENCY	3,115	3,326,825	70,678	0	22,684,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	541	0	59,681	0	6,753,045	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,538	7,154,505	2,123,457	848,922	175,765,142	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	2	0	423	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
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)	180,418	411,754	529,759	1,070,217	630,930	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.408391	0.057552	0.249430	1.260678	0.003590	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,945	27,626	117,116	65,335	100,453	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.154402	0.003861	0.055142	0.076962	0.000572	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:18 am

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00590	ADMINISTRATIVE AND GENERAL			5.02
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	3,905		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,976		30.00
31.00	03100	INTENSIVE CARE UNIT	594		31.00
43.00	04300	NURSERY	335		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
54.01	05401	ULTRASOUND	0		54.01
56.00	05600	RADIOISOTOPE	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	0		58.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03610	SLEEP LAB	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,905		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OTHER NRCC	0		194.00
194.01	07951	MARKETING	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	FREE MEALS	0		194.03
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)	102,242		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.182330		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	677		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.173367		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,743,352		5,743,352	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,042,406		1,042,406	0	0	31.00
43.00	04300	NURSERY	295,590		295,590	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,305,710		2,305,710	0	0	50.00
51.00	05100	RECOVERY ROOM	567,409		567,409	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,868,725		2,868,725	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,663,911		2,663,911	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	828,339	0	828,339	0	0	65.00
66.00	06600	PHYSICAL THERAPY	739,463	0	739,463	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,935	0	215,935	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,676	0	29,676	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	320,365		320,365	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,699		186,699	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	918,582		918,582	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,377,039		2,377,039	0	0	73.00
76.00	03610	SLEEP LAB	220,882		220,882	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	517,203		517,203	0	0	90.00
91.00	09100	EMERGENCY	6,705,457		6,705,457	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	991,403		991,403		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	745,163		745,163	0	0	95.00
200.00		Subtotal (see instructions)	30,283,309	0	30,283,309	0	0	200.00
201.00		Less Observation Beds	991,403		991,403		0	201.00
202.00		Total (see instructions)	29,291,906	0	29,291,906	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 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	6,127,173		6,127,173			30.00
31.00	03100	INTENSIVE CARE UNIT	1,443,892		1,443,892			31.00
43.00	04300	NURSERY	382,225		382,225			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,421,752	15,352,133	20,773,885	0.110991	0.000000	50.00
51.00	05100	RECOVERY ROOM	700,174	2,876,112	3,576,286	0.158659	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,494,521	31,438,219	37,932,740	0.075627	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	6,343,532	18,664,360	25,007,892	0.106523	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,785,349	565,687	2,351,036	0.352329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	540,197	2,277,849	2,818,046	0.262403	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	359,443	799,327	1,158,770	0.186348	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,252	87,280	105,532	0.281204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,842,733	4,208,952	6,051,685	0.052938	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,706,907	2,792,291	5,499,198	0.033950	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,678,363	1,314,035	3,992,398	0.230083	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,461,156	11,383,471	25,844,627	0.091974	0.000000	73.00
76.00	03610	SLEEP LAB	9,842	709,417	719,259	0.307097	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,802	633,654	695,456	0.743689	0.000000	90.00
91.00	09100	EMERGENCY	2,839,342	19,845,265	22,684,607	0.295595	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	378,733	1,468,657	1,847,390	0.536651	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,753,045	6,753,045	0.110345	0.000000	95.00
200.00		Subtotal (see instructions)	54,595,388	121,169,754	175,765,142			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	54,595,388	121,169,754	175,765,142			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 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
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,743,352		5,743,352	0	5,743,352	30.00
31.00	03100	INTENSIVE CARE UNIT	1,042,406		1,042,406	0	1,042,406	31.00
43.00	04300	NURSERY	295,590		295,590	0	295,590	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,305,710		2,305,710	0	2,305,710	50.00
51.00	05100	RECOVERY ROOM	567,409		567,409	0	567,409	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,868,725		2,868,725	0	2,868,725	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,663,911		2,663,911	0	2,663,911	60.00
65.00	06500	RESPIRATORY THERAPY	828,339	0	828,339	0	828,339	65.00
66.00	06600	PHYSICAL THERAPY	739,463	0	739,463	0	739,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,935	0	215,935	0	215,935	67.00
68.00	06800	SPEECH PATHOLOGY	29,676	0	29,676	0	29,676	68.00
69.00	06900	ELECTROCARDIOLOGY	320,365		320,365	0	320,365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,699		186,699	0	186,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	918,582		918,582	0	918,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,377,039		2,377,039	0	2,377,039	73.00
76.00	03610	SLEEP LAB	220,882		220,882	0	220,882	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	517,203		517,203	0	517,203	90.00
91.00	09100	EMERGENCY	6,705,457		6,705,457	0	6,705,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	991,403		991,403		991,403	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	745,163		745,163	0	745,163	95.00
200.00		Subtotal (see instructions)	30,283,309	0	30,283,309	0	30,283,309	200.00
201.00		Less Observation Beds	991,403		991,403		991,403	201.00
202.00		Total (see instructions)	29,291,906	0	29,291,906	0	29,291,906	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,127,173		6,127,173			30.00
31.00	03100	INTENSIVE CARE UNIT	1,443,892		1,443,892			31.00
43.00	04300	NURSERY	382,225		382,225			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,421,752	15,352,133	20,773,885	0.110991	0.000000	50.00
51.00	05100	RECOVERY ROOM	700,174	2,876,112	3,576,286	0.158659	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,494,521	31,438,219	37,932,740	0.075627	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	6,343,532	18,664,360	25,007,892	0.106523	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,785,349	565,687	2,351,036	0.352329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	540,197	2,277,849	2,818,046	0.262403	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	359,443	799,327	1,158,770	0.186348	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,252	87,280	105,532	0.281204	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,842,733	4,208,952	6,051,685	0.052938	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,706,907	2,792,291	5,499,198	0.033950	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,678,363	1,314,035	3,992,398	0.230083	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,461,156	11,383,471	25,844,627	0.091974	0.000000	73.00
76.00	03610	SLEEP LAB	9,842	709,417	719,259	0.307097	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,802	633,654	695,456	0.743689	0.000000	90.00
91.00	09100	EMERGENCY	2,839,342	19,845,265	22,684,607	0.295595	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	378,733	1,468,657	1,847,390	0.536651	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,753,045	6,753,045	0.110345	0.000000	95.00
200.00		Subtotal (see instructions)	54,595,388	121,169,754	175,765,142			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	54,595,388	121,169,754	175,765,142			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.110991	50.00
51.00	05100	RECOVERY ROOM	0.158659	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.106523	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	73.00
76.00	03610	SLEEP LAB	0.307097	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.743689	90.00
91.00	09100	EMERGENCY	0.295595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.110345	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,305,710	420,602	1,885,108	0	0	50.00
51.00	05100	RECOVERY ROOM	567,409	36,224	531,185	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,868,725	317,471	2,551,254	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,663,911	169,119	2,494,792	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	828,339	56,137	772,202	0	0	65.00
66.00	06600	PHYSICAL THERAPY	739,463	66,811	672,652	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,935	21,719	194,216	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,676	1,033	28,643	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	320,365	37,569	282,796	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,699	16,168	170,531	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	918,582	38,296	880,286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,377,039	91,903	2,285,136	0	0	73.00
76.00	03610	SLEEP LAB	220,882	45,081	175,801	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	517,203	34,785	482,418	0	0	90.00
91.00	09100	EMERGENCY	6,705,457	267,598	6,437,859	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	991,403	169,864	821,539	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	745,163	86,340	658,823	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	23,201,961	1,876,720	21,325,241	0	0	200.00
201.00		Less Observation Beds	991,403	169,864	821,539	0	0	201.00
202.00		Total (line 200 minus line 201)	22,210,558	1,706,856	20,503,702	0	0	202.00

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

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,305,710	20,773,885	0.110991		50.00
51.00	05100	RECOVERY ROOM	567,409	3,576,286	0.158659		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,868,725	37,932,740	0.075627		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	2,663,911	25,007,892	0.106523		60.00
65.00	06500	RESPIRATORY THERAPY	828,339	2,351,036	0.352329		65.00
66.00	06600	PHYSICAL THERAPY	739,463	2,818,046	0.262403		66.00
67.00	06700	OCCUPATIONAL THERAPY	215,935	1,158,770	0.186348		67.00
68.00	06800	SPEECH PATHOLOGY	29,676	105,532	0.281204		68.00
69.00	06900	ELECTROCARDIOLOGY	320,365	6,051,685	0.052938		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,699	5,499,198	0.033950		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	918,582	3,992,398	0.230083		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,377,039	25,844,627	0.091974		73.00
76.00	03610	SLEEP LAB	220,882	719,259	0.307097		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	517,203	695,456	0.743689		90.00
91.00	09100	EMERGENCY	6,705,457	22,684,607	0.295595		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	991,403	1,847,390	0.536651		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	745,163	6,753,045	0.110345		95.00
200.00		Subtotal (sum of lines 50 thru 199)	23,201,961	167,811,852			200.00
201.00		Less Observation Beds	991,403	0			201.00
202.00		Total (line 200 minus line 201)	22,210,558	167,811,852			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 11:18 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	420,602	20,773,885	0.020247	1,470,498	29,773	50.00
51.00	05100	RECOVERY ROOM	36,224	3,576,286	0.010129	206,850	2,095	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	317,471	37,932,740	0.008369	2,033,865	17,021	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	169,119	25,007,892	0.006763	2,363,593	15,985	60.00
65.00	06500	RESPIRATORY THERAPY	56,137	2,351,036	0.023878	1,119,007	26,720	65.00
66.00	06600	PHYSICAL THERAPY	66,811	2,818,046	0.023708	257,454	6,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,719	1,158,770	0.018743	193,520	3,627	67.00
68.00	06800	SPEECH PATHOLOGY	1,033	105,532	0.009789	13,597	133	68.00
69.00	06900	ELECTROCARDIOLOGY	37,569	6,051,685	0.006208	960,070	5,960	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,168	5,499,198	0.002940	1,197,571	3,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,296	3,992,398	0.009592	1,112,375	10,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,903	25,844,627	0.003556	7,024,671	24,980	73.00
76.00	03610	SLEEP LAB	45,081	719,259	0.062677	4,258	267	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,785	695,456	0.050018	4,060	203	90.00
91.00	09100	EMERGENCY	267,598	22,684,607	0.011796	5,655	67	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	169,864	1,847,390	0.091948	927	85	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,790,380	161,058,807		17,967,971	147,211	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,773,885	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,576,286	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,932,740	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,007,892	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,351,036	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,818,046	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,158,770	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	105,532	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,051,685	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,499,198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,992,398	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,844,627	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	719,259	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	695,456	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,684,607	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,847,390	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	161,058,807		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,470,498	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	206,850	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,033,865	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	2,363,593	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,119,007	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	257,454	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	193,520	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,597	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	960,070	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,197,571	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,112,375	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,024,671	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	4,258	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	4,060	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	5,655	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	927	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		17,967,971	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:18 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	0.110991	0	3,636,528	0	0	50.00
51.00	05100	RECOVERY ROOM	0.158659	0	718,770	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	0	11,853,696	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.106523	0	6,961,344	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	0	263,719	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	0	545,801	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	0	30,015	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	0	7,784	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	0	1,933,610	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	0	587,010	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	0	440,718	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	0	4,832,144	0	0	73.00
76.00	03610	SLEEP LAB	0.307097	0	164,079	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.743689	0	60,431	0	0	90.00
91.00	09100	EMERGENCY	0.295595	0	5,975,757	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	0	704,325	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.110345		0			95.00
200.00		Subtotal (see instructions)		0	38,715,731	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	38,715,731	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:18 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	403,622	0	50.00
51.00	05100	RECOVERY ROOM	114,039	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	896,459	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	741,543	0	60.00
65.00	06500	RESPIRATORY THERAPY	92,916	0	65.00
66.00	06600	PHYSICAL THERAPY	143,220	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,593	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,189	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102,361	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,929	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,402	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	444,432	0	73.00
76.00	03610	SLEEP LAB	50,388	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	44,942	0	90.00
91.00	09100	EMERGENCY	1,766,404	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	377,977	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,307,416	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,307,416	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:18 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	0.110991	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.158659	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.106523	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.307097	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.743689	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.295595	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.110345		0			95.00
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: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/31/2018 11:18 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		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
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	984,050	28,002	956,048	3,619	264.17	30.00
31.00	INTENSIVE CARE UNIT	129,024		129,024	594	217.21	31.00
43.00	NURSERY	35,103		35,103	335	104.79	43.00
200.00	Total (lines 30 through 199)	1,148,177		1,120,175	4,548		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	47	12,416	30.00
31.00	INTENSIVE CARE UNIT	17	3,693	31.00
43.00	NURSERY	18	1,886	43.00
200.00	Total (lines 30 through 199)	82	17,995	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420,602	20,773,885	0.020247	109,343	2,214	50.00
51.00	05100	RECOVERY ROOM	36,224	3,576,286	0.010129	15,465	157	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	317,471	37,932,740	0.008369	138,014	1,155	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	169,119	25,007,892	0.006763	123,511	835	60.00
65.00	06500	RESPIRATORY THERAPY	56,137	2,351,036	0.023878	52,861	1,262	65.00
66.00	06600	PHYSICAL THERAPY	66,811	2,818,046	0.023708	2,069	49	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,719	1,158,770	0.018743	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,033	105,532	0.009789	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,569	6,051,685	0.006208	36,292	225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,168	5,499,198	0.002940	32,333	95	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,296	3,992,398	0.009592	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,903	25,844,627	0.003556	315,115	1,121	73.00
76.00	03610	SLEEP LAB	45,081	719,259	0.062677	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,785	695,456	0.050018	253	13	90.00
91.00	09100	EMERGENCY	267,598	22,684,607	0.011796	46,592	550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	169,864	1,847,390	0.091948	10,933	1,005	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,790,380	161,058,807		882,781	8,681	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,619	0.00	47	30.00
31.00	03100	INTENSIVE CARE UNIT		0	594	0.00	17	31.00
43.00	04300	NURSERY		0	335	0.00	18	43.00
200.00		Total (lines 30 through 199)		0	4,548		82	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,773,885	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,576,286	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,932,740	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,007,892	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,351,036	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,818,046	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,158,770	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	105,532	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,051,685	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,499,198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,992,398	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,844,627	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	719,259	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	695,456	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,684,607	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,847,390	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	161,058,807		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	109,343	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	15,465	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	138,014	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	123,511	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	52,861	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,069	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	0.000000	36,292	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	32,333	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	315,115	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	253	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	46,592	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	10,933	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		882,781	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.110991	0	116,685	0	0	50.00
51.00	05100	RECOVERY ROOM	0.158659	0	24,044	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	0	309,467	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.106523	0	315,377	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	0	4,294	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	0	16,269	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	0	22,647	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	0	875	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	0	45,141	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	0	31,403	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	0	14,087	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	0	97,334	0	0	73.00
76.00	03610	SLEEP LAB	0.307097	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.743689	0	2,278	0	0	90.00
91.00	09100	EMERGENCY	0.295595	0	443,846	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	0	14,682	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.110345	0	138,620			95.00
200.00		Subtotal (see instructions)		0	1,597,049	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	1,597,049	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	12,951	0		50.00
51.00	05100	RECOVERY ROOM	3,815	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,404	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	33,595	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,513	0		65.00
66.00	06600	PHYSICAL THERAPY	4,269	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,220	0		67.00
68.00	06800	SPEECH PATHOLOGY	246	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,390	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,066	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,241	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,952	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,694	0		90.00
91.00	09100	EMERGENCY	131,199	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,879	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	15,296			95.00
200.00		Subtotal (see instructions)	255,730	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	255,730	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:18 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)	3,725	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,619	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,976	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	106	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,556	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)	104	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,743,352	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)	163,435	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,579,917	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)	5,579,917	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)	1,541.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,399,103	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,399,103	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:18 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	1,042,406	594	1,754.89	331	580,869	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)	2,103,329	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,083,301	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)	160,351	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)	160,351	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)	643	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,541.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	991,403	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:18 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	984,050	5,743,352	0.171337	991,403	169,864	90.00
91.00	Nursing School cost	0	5,743,352	0.000000	991,403	0	91.00
92.00	Allied health cost	0	5,743,352	0.000000	991,403	0	92.00
93.00	All other Medical Education	0	5,743,352	0.000000	991,403	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,725	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,619	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,976	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	106	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	47	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)	335	15.00
16.00	Nursery days (title V or XIX only)	18	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,743,352	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)	163,435	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,579,917	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)	5,579,917	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)	1,541.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	72,466	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)	72,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	295,590	335	882.36	18	15,882	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,042,406	594	1,754.89	17	29,833	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)	109,180	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	227,361	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)	17,995	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,681	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	26,676	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	200,685	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)	643	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,541.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	991,403	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	984,050	5,743,352	0.171337	991,403	169,864	90.00
91.00	Nursing School cost	0	5,743,352	0.000000	991,403	0	91.00
92.00	Allied health cost	0	5,743,352	0.000000	991,403	0	92.00
93.00	All other Medical Education	0	5,743,352	0.000000	991,403	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:18 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		2,945,657		30.00
31.00	03100	INTENSIVE CARE UNIT		930,441		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.110991	1,470,498	163,212	50.00
51.00	05100	RECOVERY ROOM	0.158659	206,850	32,819	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	2,033,865	153,815	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.106523	2,363,593	251,777	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	1,119,007	394,259	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	257,454	67,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	193,520	36,062	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	13,597	3,824	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	960,070	50,824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	1,197,571	40,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	1,112,375	255,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	7,024,671	646,087	73.00
76.00	03610	SLEEP LAB	0.307097	4,258	1,308	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.743689	4,060	3,019	90.00
91.00	09100	EMERGENCY	0.295595	5,655	1,672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	927	497	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,967,971	2,103,329	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)		17,967,971		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:18 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.110991	0	0	50.00
51.00	05100	RECOVERY ROOM	0.158659	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	19,777	1,496	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.106523	44,607	4,752	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	32,989	11,623	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	122,970	32,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	1,753	93	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	17,747	603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	195,530	17,984	73.00
76.00	03610	SLEEP LAB	0.307097	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.743689	0	0	90.00
91.00	09100	EMERGENCY	0.295595	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	5,390	2,893	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		440,763	71,712	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)		440,763		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:18 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		89,622		30.00
31.00	03100	INTENSIVE CARE UNIT		47,787		31.00
43.00	04300	NURSERY		20,456		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.110991	109,343	12,136	50.00
51.00	05100	RECOVERY ROOM	0.158659	15,465	2,454	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.075627	138,014	10,438	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.106523	123,511	13,157	60.00
65.00	06500	RESPIRATORY THERAPY	0.352329	52,861	18,624	65.00
66.00	06600	PHYSICAL THERAPY	0.262403	2,069	543	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186348	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.281204	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.052938	36,292	1,921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033950	32,333	1,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.230083	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.091974	315,115	28,982	73.00
76.00	03610	SLEEP LAB	0.307097	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.743689	253	188	90.00
91.00	09100	EMERGENCY	0.295595	46,592	13,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.536651	10,933	5,867	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		882,781	109,180	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)		882,781		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/31/2018 11:18 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,307,416	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,307,416	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 (see instructions)	5,360,490	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	66,611	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	6,348,865	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)	-1,054,986	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)	-1,054,986	30.00
31.00	Primary payer payments	1,045	31.00
32.00	Subtotal (line 30 minus line 31)	-1,056,031	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)	998,208	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	648,835	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	879,746	36.00
37.00	Subtotal (see instructions)	-407,196	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	-407,196	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,300,483	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,707,679	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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2018 11:18 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		3,710,462		1,300,483	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	08/08/2017	111,700		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)		111,700		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)		3,822,162		1,300,483	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		774,206		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,707,679	6.02
7.00	Total Medicare program liability (see instructions)		4,596,368		-407,196	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: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2018 11:18 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		164,293		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		164,293		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		65,403		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		229,696		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: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/31/2018 11:18 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		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1318 Component CCN: 15-Z318	Period: From 01/01/2017 To 12/31/2017	Worksheet E-2 Date/Time Prepared: 5/31/2018 11:18 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)	161,955	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)	72,429	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	104	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)	234,384	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	234,384	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)	234,384	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	234,384	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	234,384	0	19.00
19.01	Sequestration adjustment (see instructions)	4,688	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	164,293	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)	65,403	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/31/2018 11:18 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,083,301	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)	5,083,301	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,134,134	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)	5,134,134	19.00
20.00	Deductibles (exclude professional component)	484,288	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,649,846	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,649,846	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	62,039	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	40,325	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,642	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,690,171	28.00
29.00	MSP	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	4,690,171	30.00
30.01	Sequestration adjustment (see instructions)	93,803	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,822,162	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, 30.02, 31, and 32)	774,206	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	528,559	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/31/2018 11:18 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	-111,970	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	19,245,260	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,298,867	0	0	0	6.00
7.00	Inventory	1,008,430	0	0	0	7.00
8.00	Prepaid expenses	266,404	0	0	0	8.00
9.00	Other current assets	298,818	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)	15,408,075	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	218,645	0	0	0	13.00
14.00	Accumulated depreciation	-110,052	0	0	0	14.00
15.00	Buildings	10,491,181	0	0	0	15.00
16.00	Accumulated depreciation	-3,154,497	0	0	0	16.00
17.00	Leasehold improvements	9,572,354	0	0	0	17.00
18.00	Accumulated depreciation	-2,604,503	0	0	0	18.00
19.00	Fixed equipment	1,933,522	0	0	0	19.00
20.00	Accumulated depreciation	-943,043	0	0	0	20.00
21.00	Automobiles and trucks	583,590	0	0	0	21.00
22.00	Accumulated depreciation	-422,388	0	0	0	22.00
23.00	Major movable equipment	7,210,696	0	0	0	23.00
24.00	Accumulated depreciation	-5,371,257	0	0	0	24.00
25.00	Minor equipment depreciable	2,841,093	0	0	0	25.00
26.00	Accumulated depreciation	-2,355,900	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,389,441	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,792,718	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,792,718	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,590,234	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,991,762	0	0	0	37.00
38.00	Salaries, wages, and fees payable	994,089	0	0	0	38.00
39.00	Payroll taxes payable	99,371	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	-19,310,200	0	0	0	43.00
44.00	Other current liabilities	388,205	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-15,836,773	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-15,836,773	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	53,427,007				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)	53,427,007	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,590,234	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/31/2018 11:18 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		46,151,753		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,221,614				2.00
3.00	Total (sum of line 1 and line 2)		53,373,367		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)		53,373,367		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)		53,373,367		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: 15-1318 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2018 11:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,509,398		6,509,398	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)	6,509,398		6,509,398	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,443,892		1,443,892	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)	1,443,892		1,443,892	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,953,290		7,953,290	17.00
18.00	Ancillary services	46,642,098	92,469,132	139,111,230	18.00
19.00	Outpatient services	0	28,700,621	28,700,621	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	54,595,388	121,169,753	175,765,141	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,726,633		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)		31,726,633		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/31/2018 11:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	175,765,141	1.00
2.00	Less contractual allowances and discounts on patients' accounts	136,933,396	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,831,745	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,726,633	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,105,112	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	116,502	24.00
25.00	Total other income (sum of lines 6-24)	116,502	25.00
26.00	Total (line 5 plus line 25)	7,221,614	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)	7,221,614	29.00