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: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S Parts I-III Date/Time Prepared: 8/31/2017 9:44 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/31/2017 Time: 9:44 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 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 DUPONT HOSPITAL (15-0150) for the cost reporting period beginning 04/01/2016 and ending 03/31/2017 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.

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

VICE PRESIDENT REVENUE MANAGEMENT
Title

08/31/2017
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	-88,636	-60,257	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-88,636	-60,257	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 9:43 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2520 E. DUPONT ROAD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46825-	County: ALLEN	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	DUPONT HOSPITAL	150150	23060	1	05/24/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2016	03/31/2017	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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	842	741	209	136	5,544	335	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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 9:43 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 9:43 am

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

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

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

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

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

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

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

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

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

Line	Description	Premiums	Losses	Insurance	Line
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	262,924	26,131	0	118.01

Line	Description	1.00	2.00	Line
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 9:43 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC	Contractor's Number: 10301	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 9:43 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/31/2017 9:43 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	06/21/2017	Y	06/21/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/31/2017 9:43 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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	Y	12/31/2016	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: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/31/2017 9:43 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 - REVENUE MANAGEMENT		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: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2017 9:43 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	92	33,580	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		92	33,580	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	29	10,585	0.00	0	8.01
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)		131	47,815	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		131				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2017 9:43 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)	2,053	295	11,525			1.00
2.00	HMO and other (see instructions)	1,534	4,809				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,053	295	11,525			7.00
8.00	INTENSIVE CARE UNIT	359	40	1,443			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	209	4,904			8.01
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		2,119	4,733			13.00
14.00	Total (see instructions)	2,412	2,663	22,605	0.00	570.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	570.15	27.00
28.00	Observation Bed Days		0	2,323			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	335	980			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2017 9:43 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	658	1,348	6,166	1.00
2.00	HMO and other (see instructions)			434	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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	658	1,348	6,166	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-3 Part II Date/Time Prepared: 8/31/2017 9:43 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 II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	32,057,732	0	32,057,732	1,185,924.00	27.03	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	1,692	-1,692	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		20,863	612,615	633,478	21,166.00	29.93	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		587,636	0	587,636	9,632.00	61.01	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		217,247	0	217,247	1,428.00	152.13	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		2,886,753	0	2,886,753	97,039.00	29.75	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)		7,161,354	0	7,161,354			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		103,348	0	103,348			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		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	161,411	0	161,411	6,848.00	23.57	26.00
27.00	Administrative & General	5.00	4,889,335	-901,526	3,987,809	152,394.00	26.17	27.00

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		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	679,252	0	679,252	36,283.00	18.72	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	325,278	0	325,278	29,377.00	11.07	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,066,956	-455,641	611,315	36,524.00	16.74	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	455,641	455,641	33,292.00	13.69	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,243,089	288,455	1,531,544	35,850.00	42.72	38.00
39.00	Central Services and Supply	14.00	323,979	0	323,979	18,053.00	17.95	39.00
40.00	Pharmacy	15.00	1,281,905	0	1,281,905	28,310.00	45.28	40.00
41.00	Medical Records & Medical Records Library	16.00	294,814	0	294,814	16,584.00	17.78	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 8/31/2017 9:43 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)		32,057,732	0	32,057,732	1,185,924.00	27.03	1.00
2.00	Excluded area salaries (see instructions)		22,555	610,923	633,478	21,166.00	29.93	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,035,177	-610,923	31,424,254	1,164,758.00	26.98	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,691,636	0	3,691,636	108,099.00	34.15	4.00
5.00	Subtotal wage-related costs (see inst.)		7,161,354	0	7,161,354	0.00	22.79	5.00
6.00	Total (sum of lines 3 thru 5)		42,888,167	-610,923	42,277,244	1,272,857.00	33.21	6.00
7.00	Total overhead cost (see instructions)		10,266,019	-613,071	9,652,948	393,515.00	24.53	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 8/31/2017 9:43 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	568,703	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)	3,801,969	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	36,118	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	20,689	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	318	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3,832	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	311,513	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	1,826,251	17.00
18.00	Medicare Taxes - Employers Portion Only	427,107	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	123,631	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)	7,120,131	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS, RELOCATION EXPENSES,	144,572	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 8/31/2017 9:43 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	7,264,703	1.00
2.00	Hospital	0	7,264,703	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet S-10 Date/Time Prepared: 8/31/2017 9:43 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)	0.134291	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,910,458	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	5,340,270	5.00
6.00	Medicaid charges	99,603,626	6.00
7.00	Medicaid cost (line 1 times line 6)	13,375,871	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)	5,417	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	98,010	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	13,162	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)	7,745	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	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)	7,745	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	538,176	946,175	1,484,351	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	72,272	127,063	199,335	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	72,272	127,063	199,335	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,913,863	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	180,943	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,732,920	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	904,171	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,103,506	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,111,251	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/31/2017 9:43 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		1,494,438	1,494,438	1,451,482	2,945,920	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,821,747	3,821,747	2,573,601	6,395,348	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	161,411	190,788	352,199	4,816,390	5,168,589	4.00
5.01	00570	ADMITTING	0	0	0	2,176,116	2,176,116	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,622,977	1,622,977	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	4,889,335	39,565,612	44,454,947	-12,552,028	31,902,919	5.03
7.00	00700	OPERATION OF PLANT	679,252	2,983,414	3,662,666	-202	3,662,464	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	398,750	398,750	0	398,750	8.00
9.00	00900	HOUSEKEEPING	325,278	479,022	804,300	0	804,300	9.00
10.00	01000	DIETARY	1,066,956	1,131,274	2,198,230	-1,070,770	1,127,460	10.00
11.00	01100	CAFETERIA	0	0	0	1,065,529	1,065,529	11.00
13.00	01300	NURSING ADMINISTRATION	1,243,089	153,995	1,397,084	286,918	1,684,002	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	323,979	10,824,477	11,148,456	-9,934,321	1,214,135	14.00
15.00	01500	PHARMACY	1,281,905	4,657,652	5,939,557	-4,639,734	1,299,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	294,814	838,655	1,133,469	-9,408	1,124,061	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,363,394	2,163,751	9,527,145	-2,867,387	6,659,758	30.00
31.00	03100	INTENSIVE CARE UNIT	827,960	270,637	1,098,597	-44	1,098,553	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,292,690	537,127	2,829,817	0	2,829,817	31.01
40.00	04000	SUBPROVIDER - IPF	456	35	491	-491	0	40.00
43.00	04300	NURSERY	87	175,582	175,669	1,250,262	1,425,931	43.00
44.00	04400	SKILLED NURSING FACILITY	1,692	150	1,842	-1,842	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,039,627	5,155,895	8,195,522	1,356,257	9,551,779	50.00
51.00	05100	RECOVERY ROOM	1,681,521	541,760	2,223,281	-2,223,281	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,404	967,171	972,575	1,598,215	2,570,790	52.00
53.00	05300	ANESTHESIOLOGY	0	1,949,493	1,949,493	-293	1,949,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,505,119	779,906	2,285,025	-315,320	1,969,705	54.00
54.01	05401	ULTRA SOUND	327,511	29,763	357,274	0	357,274	54.01
56.00	05600	RADIOISOTOPE	59,968	141,231	201,199	0	201,199	56.00
57.00	05700	CT SCAN	0	62,279	62,279	-62,279	0	57.00
58.00	05800	MRI	167,043	36,425	203,468	0	203,468	58.00
60.00	06000	LABORATORY	1,427,109	1,381,353	2,808,462	-127,163	2,681,299	60.00
65.00	06500	RESPIRATORY THERAPY	926,244	314,598	1,240,842	-44,659	1,196,183	65.00
66.00	06600	PHYSICAL THERAPY	157,259	12,339	169,598	163,118	332,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,419	7,453	103,872	-103,872	0	67.00
68.00	06800	SPEECH PATHOLOGY	54,189	5,058	59,247	-59,247	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,332	5,752	62,084	0	62,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,887,548	3,887,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,806,874	5,806,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,525,259	4,525,259	73.00
74.00	07400	RENAL DIALYSIS	0	145,414	145,414	0	145,414	74.00
76.00	03950	SLEEP LAB	220,545	194,786	415,331	-58,043	357,288	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	332,838	86,721	419,559	0	419,559	90.00
91.00	09100	EMERGENCY	1,227,899	522,985	1,750,884	61,137	1,812,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	61,201	61,201	-61,201	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,037,325	82,088,689	114,126,014	-1,489,902	112,636,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,876	4,614	8,490	0	8,490	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,531	22,210	38,741	-101	38,640	192.00
194.00	07950	MARKETING	0	0	0	951,551	951,551	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,968	1,968	0	1,968	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	0	538,452	538,452	194.03
200.00		TOTAL (SUM OF LINES 118-199)	32,057,732	82,117,481	114,175,213	0	114,175,213	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/31/2017 9:43 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	761,607	3,707,527	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-95,598	6,299,750	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,862	5,160,727	4.00
5.01	00570	ADMITTING	0	2,176,116	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	-82,081	1,540,896	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-18,188,258	13,714,661	5.03
7.00	00700	OPERATION OF PLANT	-54,032	3,608,432	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,498	536,248	8.00
9.00	00900	HOUSEKEEPING	0	804,300	9.00
10.00	01000	DIETARY	0	1,127,460	10.00
11.00	01100	CAFETERIA	-382,419	683,110	11.00
13.00	01300	NURSING ADMINISTRATION	-3,497	1,680,505	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,214,135	14.00
15.00	01500	PHARMACY	0	1,299,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-383	1,123,678	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-661,797	5,997,961	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,098,553	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-81,000	2,748,817	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	1,425,931	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	9,551,779	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-400,000	2,170,790	52.00
53.00	05300	ANESTHESIOLOGY	-1,949,200	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,325	1,966,380	54.00
54.01	05401	ULTRA SOUND	0	357,274	54.01
56.00	05600	RADIOISOTOPE	0	201,199	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	203,468	58.00
60.00	06000	LABORATORY	-181,027	2,500,272	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,196,183	65.00
66.00	06600	PHYSICAL THERAPY	0	332,716	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	62,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,887,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,806,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,525,259	73.00
74.00	07400	RENAL DIALYSIS	0	145,414	74.00
76.00	03950	SLEEP LAB	-59,020	298,268	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	419,559	90.00
91.00	09100	EMERGENCY	-45,245	1,766,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-21,295,639	91,340,473	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,490	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,640	192.00
194.00	07950	MARKETING	0	951,551	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,968	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	538,452	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-21,295,639	92,879,574	200.00

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/31/2017 9:43 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,816,598	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	4,816,598	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	67,346	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	67,346	
	C - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,569,995	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	TOTALS		0	2,569,995	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	65,586	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,385,896	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,606	3.00
	TOTALS		0	1,455,088	
	E - MARKETING				
1.00	MARKETING	194.00	136,172	815,379	1.00
	TOTALS		136,172	815,379	
	F - CNO SALARIES				
1.00	NURSING ADMINISTRATION	13.00	288,455	0	1.00
	TOTALS		288,455	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,820,202	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,806,874	2.00
3.00	OPERATING ROOM	50.00	0	31,795	3.00
	TOTALS		0	9,658,871	
	H - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,525,259	1.00
	TOTALS		0	4,525,259	
	I - MISCELLANEOUS				
1.00	ADMITTING	5.01	1,902,916	273,200	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.02	0	1,622,977	2.00
	TOTALS		1,902,916	1,896,177	
	J - RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,279	1.00
	TOTALS		0	62,279	
	K - DIETARY				
1.00	CAFETERIA	11.00	455,641	609,888	1.00
	TOTALS		455,641	609,888	
	L - MISC DEPT RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	2,148	186	1.00
2.00	OPERATING ROOM	50.00	1,681,521	542,053	2.00
3.00	PHYSICAL THERAPY	66.00	150,608	12,510	3.00
4.00	EMERGENCY	91.00	0	61,201	4.00
5.00	WOMENS RESOURCE CENTER	194.03	476,899	61,553	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
	TOTALS		2,311,176	677,503	
	M - LABOR & DELIVERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	0	100,402	1.00
2.00	NURSERY	43.00	1,053,959	196,303	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	1,894,920	0	3.00
	TOTALS		2,948,879	296,705	

RECLASSIFICATIONS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet A-6 Date/Time Prepared: 8/31/2017 9:43 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
500.00	Grand Total: Increases		8,043,239	27,451,088	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFIT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	4,816,577	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	21	0		2.00
	TOTALS		0	4,816,598			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	22,687	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	44,659	0		2.00
	TOTALS		0	67,346			
	C - RENTAL AND LEASE EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	208	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	702,812	0		2.00
3.00	OPERATION OF PLANT	7.00	0	202	0		3.00
4.00	DIETARY	10.00	0	5,241	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,516	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	255,340	0		6.00
7.00	PHARMACY	15.00	0	114,475	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,408	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	21,244	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	44	0		10.00
11.00	OPERATING ROOM	50.00	0	899,112	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	375,022	0		12.00
13.00	LABORATORY	60.00	0	127,163	0		13.00
14.00	SLEEP LAB	76.00	0	58,043	0		14.00
15.00	EMERGENCY	91.00	0	64	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	101	0		16.00
	TOTALS		0	2,569,995			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,455,088	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	1,455,088			
	E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	136,172	815,379	0		1.00
	TOTALS		136,172	815,379			
	F - CNO SALARIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	288,455	0	0		1.00
	TOTALS		288,455	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,656,294	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,577	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	9,658,871			
	H - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	4,525,259	0		1.00
	TOTALS		0	4,525,259			
	I - MISCELLANEOUS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	1,902,916	1,896,177	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,902,916	1,896,177			
	J - RADIOLOGY COSTS						
1.00	CT SCAN	57.00	0	62,279	0		1.00
	TOTALS		0	62,279			
	K - DIETARY						
1.00	DIETARY	10.00	455,641	609,888	0		1.00
	TOTALS		455,641	609,888			
	L - MISC DEPT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	476,899	61,553	0		1.00
2.00	SUBPROVIDER - IPF	40.00	456	35	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	1,692	150	0		3.00
4.00	RECOVERY ROOM	51.00	1,681,521	541,760	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	293	0		5.00
6.00	OCCUPATIONAL THERAPY	67.00	96,419	7,453	0		6.00
7.00	SPEECH PATHOLOGY	68.00	54,189	5,058	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	61,201	0		8.00
	TOTALS		2,311,176	677,503			

RECLASSIFICATIONS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet A-6 Date/Time Prepared: 8/31/2017 9:43 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	M - LABOR & DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	2,948,879	0	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	296,705	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		2,948,879	296,705		
500.00	Grand Total: Decreases		8,043,239	27,451,088		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part I Date/Time Prepared: 8/31/2017 9:43 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	1,732,541	0	0	0	0	1.00
2.00	Land Improvements	445,674	23,303	0	23,303	0	2.00
3.00	Buildings and Fixtures	55,661,764	99,282	0	99,282	0	3.00
4.00	Building Improvements	3,989,303	649,593	0	649,593	0	4.00
5.00	Fixed Equipment	3,954,346	405	0	405	44,910	5.00
6.00	Movable Equipment	54,068,334	3,934,819	0	3,934,819	143,971	6.00
7.00	HIT designated Assets	377,130	2,609	0	2,609	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,229,092	4,710,011	0	4,710,011	188,881	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	120,229,092	4,710,011	0	4,710,011	188,881	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,732,541	0	1.00
2.00	Land Improvements	468,977	0	2.00
3.00	Buildings and Fixtures	55,761,046	0	3.00
4.00	Building Improvements	4,638,896	0	4.00
5.00	Fixed Equipment	3,909,841	0	5.00
6.00	Movable Equipment	57,859,182	0	6.00
7.00	HIT designated Assets	379,739	0	7.00
8.00	Subtotal (sum of lines 1-7)	124,750,222	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	124,750,222	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet A-7 Part II Date/Time Prepared: 8/31/2017 9:43 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	1,494,438	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,821,747	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,316,185	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,494,438	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,821,747	2.00
3.00	Total (sum of lines 1-2)	0	5,316,185	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 8/31/2017 9:43 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	62,670,897	0	62,670,897	0.502371	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	62,079,326	0	62,079,326	0.497629	0	2.00
3.00	Total (sum of lines 1-2)	124,750,223	0	124,750,223	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	1,913,487	-75,934	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,012,310	2,123,402	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,925,797	2,047,468	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	418,492	65,586	1,385,896	0	3,707,527	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	160,432	3,606	0	0	6,299,750	2.00
3.00	Total (sum of lines 1-2)	578,924	69,192	1,385,896	0	10,007,277	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/31/2017 9:43 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	-61,430	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,410,606			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	74,391			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-382,419	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	-383	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	419,049	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	190,563	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)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SILVER RECOVERY	B	-3,325	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
35.00	RENTAL INCOME	B	-75,934	CAP REL COSTS-BLDG & FIXT	1.00	10	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/31/2017 9:43 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.00	MISC INCOME	B	-702,473	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.00
38.00	TRAINING REVENUE	B	-1,035	NURSING ADMINISTRATION	13.00	0	38.00
39.00	PATIENT PHONE BENEFITS COST	A	-7,862	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PHOTO COMMISSION	B	-2,198	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	40.00
41.00	PATIENT TV EXPENSE	A	-54,032	OPERATION OF PLANT	7.00	0	41.00
42.00	MARKETING	A	-25,407	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.00
43.00	MINORITY INTEREST	A	-15,833,483	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	43.00
44.00	PHYSICIAN RECRUITING	A	-807,497	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	44.00
45.00	LOBBYING EXPENSE	A	-10,159	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.00
45.01	CHARITABLE CONTRIBUTIONS	A	-103,547	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.01
45.02	MEALS & ENTERTAINMENT	A	-8,248	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.02
45.03	MOB SUPPORT COSTS	A	-446,593	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.03
45.04	LEGAL FEES	A	-43,011	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,295,639				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: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2017 9:43 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	DIRECT ALLOCATION INTEREST	415,840	0	1.00
2.00	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI OPERATING COSTS	621,408	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	41,784	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	6,557	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL - BLDGS	16,819	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL - FIXTURES	232,344	0	4.02
4.03	5.03	OTHER ADMINISTRATIVE AND GEN	POOLED ADMIN COSTS	2,796,705	0	4.03
4.04	5.03	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	1,211,461	4.04
4.05	5.03	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	8,968	4.05
4.06	5.03	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	223,574	4.06
4.07	5.03	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1,616,352	4.07
4.08	5.03	OTHER ADMINISTRATIVE AND GEN	CIG RENTAL	0	349,731	4.08
4.12	5.03	OTHER ADMINISTRATIVE AND GEN	CIG TAX	0	24,481	4.12
4.15	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI COLLECTION FEES	0	631,934	4.15
4.16	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI LIEN UNIT	0	70,530	4.16
4.17	5.03	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE	76,228	311,913	4.17
4.18	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY - OPERATING	383,423	245,925	4.18
4.19	1.00	CAP REL COSTS-BLDG & FIXT	LAUNDRY - CAPITAL	45,560	115,299	4.19
4.20	1.00	CAP REL COSTS-BLDG & FIXT	DSC BLDG LEASE SJH	627,201	613,413	4.20
4.22	5.03	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE ALLOCATION	313,597	0	4.22
4.25	5.02	CASHIERING/ACCOUNTS RECEIVAB	EBOS FEES	0	1,025	4.25
4.26	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	295,743	374,212	4.26
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,873,209	5,798,818	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	CHS, INC.	72.03	CHS, INC.	72.03	6.00
7.00	B	HOSPITAL LAUNDR	100.00	HOSPITAL LAUNDR	100.00	7.00
8.00	B	LUTHERAN HEALTH	100.00	LUTHERAN HEALTH	100.00	8.00
9.00	B	PASI	100.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2017 9:43 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	415,840	11	1.00
2.00	621,408	0	2.00
3.00	41,784	11	3.00
4.00	6,557	11	4.00
4.01	16,819	11	4.01
4.02	232,344	11	4.02
4.03	2,796,705	0	4.03
4.04	-1,211,461	0	4.04
4.05	-8,968	0	4.05
4.06	-223,574	0	4.06
4.07	-1,616,352	0	4.07
4.08	-349,731	11	4.08
4.12	-24,481	0	4.12
4.15	-631,934	0	4.15
4.16	-70,530	0	4.16
4.17	-235,685	0	4.17
4.18	137,498	0	4.18
4.19	-69,739	11	4.19
4.20	13,788	11	4.20
4.22	313,597	0	4.22
4.25	-1,025	0	4.25
4.26	-78,469	11	4.26
5.00	74,391		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.

	Type of Business	
6.00	HOSPITAL MANAGEMENT	6.00
7.00	LAUNDRY	7.00
8.00	HOSPITAL NETWOR	8.00
9.00	DEBT COLLECTION	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: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2017 9:43 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	68,349	0	68,349	171,400	455	1.00
2.00	13.00	NURSING ADMINISTRATION	5,346	0	5,346	171,400	35	2.00
3.00	30.00	ADULTS & PEDIATRICS	661,797	661,797	0	0	0	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	81,000	81,000	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	400,000	400,000	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,949,200	1,949,200	0	0	0	6.00
7.00	60.00	LABORATORY	181,027	181,027	0	0	0	7.00
8.00	76.00	SLEEP LAB	59,020	59,020	0	0	0	8.00
9.00	91.00	EMERGENCY	45,245	45,245	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,450,984	3,377,289	73,695		490	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	37,494	1,875	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	2,884	144	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	76.00	SLEEP LAB	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			40,378	2,019	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	37,494	30,855	30,855		1.00
2.00	13.00	NURSING ADMINISTRATION	0	2,884	2,462	2,462		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	661,797		3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	81,000		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	400,000		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,949,200		6.00
7.00	60.00	LABORATORY	0	0	0	181,027		7.00
8.00	76.00	SLEEP LAB	0	0	0	59,020		8.00
9.00	91.00	EMERGENCY	0	0	0	45,245		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	40,378	33,317	3,410,606		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	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	3,707,527	3,707,527				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,299,750		6,299,750			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,160,727	9,492	16,129	5,186,348		4.00
5.01	00570	ADMITTING	2,176,116	0	0	309,414	2,485,530	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,540,896	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	13,714,661	124,604	211,725	339,004	0	5.03
7.00	00700	OPERATION OF PLANT	3,608,432	1,026,417	1,744,063	110,446	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	536,248	11,503	19,546	0	0	8.00
9.00	00900	HOUSEKEEPING	804,300	94,084	159,865	52,890	0	9.00
10.00	01000	DIETARY	1,127,460	0	0	99,400	0	10.00
11.00	01100	CAFETERIA	683,110	34,871	59,253	74,087	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,680,505	19,595	33,295	249,029	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,214,135	12,294	20,890	52,679	0	14.00
15.00	01500	PHARMACY	1,299,823	0	0	208,438	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,123,678	0	0	47,937	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,997,961	759,805	1,291,044	718,149	151,677	30.00
31.00	03100	INTENSIVE CARE UNIT	1,098,553	111,107	188,791	134,626	15,308	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,748,817	160,300	272,378	372,791	96,416	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,425,931	50,395	85,631	171,388	29,711	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,551,779	743,935	1,264,078	767,666	797,885	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,170,790	0	0	308,993	53,565	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,966,380	153,576	260,953	244,732	174,777	54.00
54.01	05401	ULTRA SOUND	357,274	0	0	53,253	52,497	54.01
56.00	05600	RADIOISOTOPE	201,199	0	0	9,751	13,992	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	203,468	28,411	48,276	27,161	40,079	58.00
60.00	06000	LABORATORY	2,500,272	32,465	55,164	232,048	201,355	60.00
65.00	06500	RESPIRATORY THERAPY	1,196,183	0	0	150,607	33,318	65.00
66.00	06600	PHYSICAL THERAPY	332,716	9,855	16,745	50,059	9,516	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	62,084	0	0	9,160	12,760	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,887,548	0	0	0	208,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,806,874	0	0	0	149,632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,525,259	0	0	0	283,434	73.00
74.00	07400	RENAL DIALYSIS	145,414	0	0	0	2,624	74.00
76.00	03950	SLEEP LAB	298,268	36,849	62,613	35,861	12,810	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	419,559	0	0	54,119	9,964	90.00
91.00	09100	EMERGENCY	1,766,776	131,394	223,262	199,656	135,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,340,473	3,550,952	6,033,701	5,083,344	2,485,530	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,490	9,311	15,821	630	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,640	0	0	2,688	0	192.00
194.00	07950	MARKETING	951,551	0	0	22,142	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,968	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	538,452	147,264	250,228	77,544	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 118-201)	92,879,574	3,707,527	6,299,750	5,186,348	2,485,530	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
	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	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,540,896					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	14,389,994	14,389,994			5.03
7.00	00700	OPERATION OF PLANT	0	6,489,358	1,189,733	7,679,091		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	567,297	104,006	34,681	705,984	8.00
9.00	00900	HOUSEKEEPING	0	1,111,139	203,712	283,656	0	9.00
10.00	01000	DIETARY	0	1,226,860	224,928	0	0	10.00
11.00	01100	CAFETERIA	0	851,321	156,078	105,135	3,071	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,982,424	363,450	59,076	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,299,998	238,336	37,066	0	14.00
15.00	01500	PHARMACY	0	1,508,261	276,519	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,171,615	214,799	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	94,028	9,012,664	1,652,346	2,290,766	202,041	30.00
31.00	03100	INTENSIVE CARE UNIT	9,489	1,557,874	285,614	334,982	31,909	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	59,770	3,710,472	680,263	483,294	9,353	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	18,418	1,781,474	326,608	151,939	8,851	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	494,694	13,620,037	2,497,071	2,242,917	198,649	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,206	2,566,554	470,542	0	115,390	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,348	2,908,766	533,282	463,022	52,766	54.00
54.01	05401	ULTRA SOUND	32,544	495,568	90,855	0	0	54.01
56.00	05600	RADIOISOTOPE	8,674	233,616	42,830	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	24,845	372,240	68,245	85,658	0	58.00
60.00	06000	LABORATORY	124,824	3,146,128	576,799	97,881	27	60.00
65.00	06500	RESPIRATORY THERAPY	20,654	1,400,762	256,810	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,899	424,790	77,879	29,712	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	7,910	91,914	16,851	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	129,207	4,225,181	774,628	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	92,760	6,049,266	1,109,048	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	175,706	4,984,399	913,820	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,627	149,665	27,439	0	0	74.00
76.00	03950	SLEEP LAB	7,941	454,342	83,297	111,097	8,484	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,177	489,819	89,801	0	0	90.00
91.00	09100	EMERGENCY	84,175	2,541,047	465,865	396,145	75,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,540,896	90,814,845	14,011,454	7,207,027	705,984	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,252	6,280	28,072	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	41,328	7,577	0	0	192.00
194.00	07950	MARKETING	0	973,693	178,513	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,968	361	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,013,488	185,809	443,992	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 118-201)	1,540,896	92,879,574	14,389,994	7,679,091	705,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,598,507					9.00
10.00	01000	DIETARY	0	1,451,788				10.00
11.00	01100	CAFETERIA	22,832	0	1,138,437			11.00
13.00	01300	NURSING ADMINISTRATION	12,829	0	43,887	2,461,666		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,049	0	23,242	0	1,606,691	14.00
15.00	01500	PHARMACY	0	0	36,443	144,255	4,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	21,341	0	369	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	497,478	930,999	204,199	808,295	38,641	30.00
31.00	03100	INTENSIVE CARE UNIT	72,747	42,167	36,604	144,891	13,172	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	104,955	272,124	94,816	375,318	27,793	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	32,996	206,498	44,904	177,749	18,343	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,086	0	222,032	0	344,517	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	80,946	320,414	55,851	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,553	0	67,799	0	45,666	54.00
54.01	05401	ULTRA SOUND	0	0	12,960	0	319	54.01
56.00	05600	RADIOISOTOPE	0	0	2,704	0	2,516	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	18,602	0	6,534	0	1,812	58.00
60.00	06000	LABORATORY	21,256	0	82,044	0	51,268	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	40,620	160,790	16,355	65.00
66.00	06600	PHYSICAL THERAPY	6,452	0	9,345	0	111	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	3,990	0	59	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	382,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	560,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	24,127	0	13,254	52,466	3,376	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	11,487	45,471	6,952	90.00
91.00	09100	EMERGENCY	86,029	0	58,614	232,017	29,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,495,991	1,451,788	1,117,765	2,461,666	1,604,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,096	0	241	0	64	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	723	0	197	192.00
194.00	07950	MARKETING	0	0	5,891	0	179	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	96,420	0	13,817	0	2,089	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 118-201)	1,598,507	1,451,788	1,138,437	2,461,666	1,606,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	1,970,024					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,408,124				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	85,944	15,723,373	0	15,723,373	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,674	2,528,634	0	2,528,634	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	54,632	5,813,020	0	5,813,020	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	16,835	2,766,197	0	2,766,197	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	451,866	20,064,175	0	20,064,175	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,351	3,640,048	0	3,640,048	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,033	4,270,887	0	4,270,887	54.00
54.01	05401	ULTRA SOUND	0	29,746	629,448	0	629,448	54.01
56.00	05600	RADIOISOTOPE	0	7,928	289,594	0	289,594	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	22,709	575,800	0	575,800	58.00
60.00	06000	LABORATORY	0	114,092	4,089,495	0	4,089,495	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,879	1,894,216	0	1,894,216	65.00
66.00	06600	PHYSICAL THERAPY	0	5,392	553,681	0	553,681	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	7,230	120,044	0	120,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	118,099	5,500,831	0	5,500,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,785	7,803,640	0	7,803,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,970,024	160,600	8,028,843	0	8,028,843	73.00
74.00	07400	RENAL DIALYSIS	0	1,487	178,591	0	178,591	74.00
76.00	03950	SLEEP LAB	0	7,258	757,701	0	757,701	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5,646	649,176	0	649,176	90.00
91.00	09100	EMERGENCY	0	76,938	3,961,130	0	3,961,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,970,024	1,408,124	89,838,524	0	89,838,524	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	75,005	0	75,005	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	49,825	0	49,825	192.00
194.00	07950	MARKETING	0	0	1,158,276	0	1,158,276	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	2,329	0	2,329	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	1,755,615	0	1,755,615	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 118-201)	1,970,024	1,408,124	92,879,574	0	92,879,574	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,492	16,129	25,621	25,621	4.00
5.01	00570	ADMITTING	0	0	0	0	1,528	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	124,604	211,725	336,329	1,674	5.03
7.00	00700	OPERATION OF PLANT	0	1,026,417	1,744,063	2,770,480	545	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,503	19,546	31,049	0	8.00
9.00	00900	HOUSEKEEPING	0	94,084	159,865	253,949	261	9.00
10.00	01000	DIETARY	0	0	0	0	491	10.00
11.00	01100	CAFETERIA	0	34,871	59,253	94,124	366	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,595	33,295	52,890	1,230	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,294	20,890	33,184	260	14.00
15.00	01500	PHARMACY	0	0	0	0	1,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	237	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	759,805	1,291,044	2,050,849	3,547	30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,107	188,791	299,898	665	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	160,300	272,378	432,678	1,841	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	50,395	85,631	136,026	846	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	743,935	1,264,078	2,008,013	3,801	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	1,526	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,576	260,953	414,529	1,209	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	263	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	48	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	28,411	48,276	76,687	134	58.00
60.00	06000	LABORATORY	0	32,465	55,164	87,629	1,146	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	744	65.00
66.00	06600	PHYSICAL THERAPY	0	9,855	16,745	26,600	247	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	45	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	36,849	62,613	99,462	177	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	267	90.00
91.00	09100	EMERGENCY	0	131,394	223,262	354,656	986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,550,952	6,033,701	9,584,653	25,113	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,311	15,821	25,132	3	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	13	192.00
194.00	07950	MARKETING	0	0	0	0	109	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	147,264	250,228	397,492	383	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 118-201)	0	3,707,527	6,299,750	10,007,277	25,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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	1,528					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	338,003			5.03
7.00	00700	OPERATION OF PLANT	0	0	27,943	2,798,968		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,443	12,641	46,133	8.00
9.00	00900	HOUSEKEEPING	0	0	4,785	103,390	0	9.00
10.00	01000	DIETARY	0	0	5,283	0	0	10.00
11.00	01100	CAFETERIA	0	0	3,666	38,321	201	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,536	21,533	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	5,598	13,510	0	14.00
15.00	01500	PHARMACY	0	0	6,495	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	5,045	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82	0	38,809	834,965	13,203	30.00
31.00	03100	INTENSIVE CARE UNIT	8	0	6,708	122,098	2,085	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	52	0	15,977	176,157	611	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	16	0	7,671	55,381	578	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	619	0	58,674	817,525	12,981	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29	0	11,052	0	7,540	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94	0	12,525	168,768	3,448	54.00
54.01	05401	ULTRA SOUND	28	0	2,134	0	0	54.01
56.00	05600	RADIOISOTOPE	8	0	1,006	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	22	0	1,603	31,222	0	58.00
60.00	06000	LABORATORY	108	0	13,547	35,677	2	60.00
65.00	06500	RESPIRATORY THERAPY	18	0	6,032	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5	0	1,829	10,830	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	7	0	396	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112	0	18,194	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81	0	26,048	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153	0	21,463	0	0	73.00
74.00	07400	RENAL DIALYSIS	1	0	644	0	0	74.00
76.00	03950	SLEEP LAB	7	0	1,956	40,494	554	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5	0	2,109	0	0	90.00
91.00	09100	EMERGENCY	73	0	10,942	144,392	4,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,528	0	329,113	2,626,904	46,133	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	147	10,232	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	178	0	0	192.00
194.00	07950	MARKETING	0	0	4,193	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	8	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	4,364	161,832	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 118-201)	1,528	0	338,003	2,798,968	46,133	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
	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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	362,385					9.00
10.00	01000	DIETARY	0	5,774				10.00
11.00	01100	CAFETERIA	5,176	0	141,854			11.00
13.00	01300	NURSING ADMINISTRATION	2,908	0	5,468	92,565		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,825	0	2,896	0	57,273	14.00
15.00	01500	PHARMACY	0	0	4,541	5,424	162	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,659	0	13	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	112,778	3,703	25,444	30,395	1,377	30.00
31.00	03100	INTENSIVE CARE UNIT	16,492	168	4,561	5,448	470	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	23,794	1,082	11,814	14,113	991	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	7,480	821	5,595	6,684	654	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	110,423	0	27,668	0	12,280	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	10,086	12,048	1,991	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,796	0	8,448	0	1,628	54.00
54.01	05401	ULTRA SOUND	0	0	1,615	0	11	54.01
56.00	05600	RADIOISOTOPE	0	0	337	0	90	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	4,217	0	814	0	65	58.00
60.00	06000	LABORATORY	4,819	0	10,223	0	1,827	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,061	6,046	583	65.00
66.00	06600	PHYSICAL THERAPY	1,463	0	1,164	0	4	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	497	0	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	5,470	0	1,652	1,973	120	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	1,431	1,710	248	90.00
91.00	09100	EMERGENCY	19,503	0	7,304	8,724	1,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	339,144	5,774	139,278	92,565	57,184	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,382	0	30	0	2	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	90	0	7	192.00
194.00	07950	MARKETING	0	0	734	0	6	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	21,859	0	1,722	0	74	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 118-201)	362,385	5,774	141,854	92,565	57,273	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	17,651					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,954				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	490	3,115,642	0	3,115,642	30.00
31.00	03100	INTENSIVE CARE UNIT	0	49	458,650	0	458,650	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	311	679,421	0	679,421	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	96	221,848	0	221,848	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,504	3,054,488	0	3,054,488	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	173	44,445	0	44,445	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	565	634,010	0	634,010	54.00
54.01	05401	ULTRA SOUND	0	170	4,221	0	4,221	54.01
56.00	05600	RADIOISOTOPE	0	45	1,534	0	1,534	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	129	114,893	0	114,893	58.00
60.00	06000	LABORATORY	0	650	155,628	0	155,628	60.00
65.00	06500	RESPIRATORY THERAPY	0	108	18,592	0	18,592	65.00
66.00	06600	PHYSICAL THERAPY	0	31	42,173	0	42,173	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	41	988	0	988	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	673	32,628	0	32,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	483	46,596	0	46,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,651	916	40,183	0	40,183	73.00
74.00	07400	RENAL DIALYSIS	0	8	653	0	653	74.00
76.00	03950	SLEEP LAB	0	41	151,906	0	151,906	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32	5,802	0	5,802	90.00
91.00	09100	EMERGENCY	0	439	552,984	0	552,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,651	7,954	9,377,285	0	9,377,285	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,928	0	36,928	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	288	0	288	192.00
194.00	07950	MARKETING	0	0	5,042	0	5,042	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	8	0	8	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	587,726	0	587,726	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 118-201)	17,651	7,954	10,007,277	0	10,007,277	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,973					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		224,973				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576	576	31,896,321			4.00
5.01	00570	ADMITTING	0	0	1,902,916	668,985,133		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	668,985,133	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	7,561	7,561	2,084,893	0	0	5.03
7.00	00700	OPERATION OF PLANT	62,283	62,283	679,252	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	698	698	0	0	0	8.00
9.00	00900	HOUSEKEEPING	5,709	5,709	325,278	0	0	9.00
10.00	01000	DIETARY	0	0	611,315	0	0	10.00
11.00	01100	CAFETERIA	2,116	2,116	455,641	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,189	1,189	1,531,544	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	746	746	323,979	0	0	14.00
15.00	01500	PHARMACY	0	0	1,281,905	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	294,814	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,105	46,105	4,416,663	40,828,365	40,828,365	30.00
31.00	03100	INTENSIVE CARE UNIT	6,742	6,742	827,960	4,120,473	4,120,473	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	9,727	9,727	2,292,690	25,953,293	25,953,293	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	3,058	3,058	1,054,046	7,997,552	7,997,552	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,142	45,142	4,721,148	214,706,144	214,706,144	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,900,324	14,418,670	14,418,670	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,319	9,319	1,505,119	47,046,332	47,046,332	54.00
54.01	05401	ULTRA SOUND	0	0	327,511	14,130,997	14,130,997	54.01
56.00	05600	RADIOISOTOPE	0	0	59,968	3,766,328	3,766,328	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	1,724	1,724	167,043	10,788,303	10,788,303	58.00
60.00	06000	LABORATORY	1,970	1,970	1,427,109	54,200,548	54,200,548	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	926,244	8,968,513	8,968,513	65.00
66.00	06600	PHYSICAL THERAPY	598	598	307,867	2,561,583	2,561,583	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	56,332	3,434,675	3,434,675	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	56,103,896	56,103,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,277,925	40,277,925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,294,540	76,294,540	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	706,307	706,307	74.00
76.00	03950	SLEEP LAB	2,236	2,236	220,545	3,448,176	3,448,176	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	332,838	2,682,229	2,682,229	90.00
91.00	09100	EMERGENCY	7,973	7,973	1,227,899	36,550,284	36,550,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	215,472	215,472	31,262,843	668,985,133	668,985,133	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	565	565	3,876	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	16,531	0	0	192.00
194.00	07950	MARKETING	0	0	136,172	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	8,936	8,936	476,899	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)	3,707,527	6,299,750	5,186,348	2,485,530	1,540,896	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.479875	28.002249	0.162600	0.003715	0.002303	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,621	1,528	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000803	0.000002	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-14,389,994	78,489,580				5.03
7.00	00700	OPERATION OF PLANT	0	6,489,358	154,553			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	567,297	698	658,822		8.00
9.00	00900	HOUSEKEEPING	0	1,111,139	5,709	0	148,146	9.00
10.00	01000	DIETARY	0	1,226,860	0	0	0	10.00
11.00	01100	CAFETERIA	0	851,321	2,116	2,866	2,116	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,982,424	1,189	0	1,189	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,299,998	746	0	746	14.00
15.00	01500	PHARMACY	0	1,508,261	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,171,615	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,012,664	46,105	188,544	46,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,557,874	6,742	29,777	6,742	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,710,472	9,727	8,728	9,727	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	1,781,474	3,058	8,260	3,058	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,620,037	45,142	185,379	45,142	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,566,554	0	107,682	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,908,766	9,319	49,241	9,319	54.00
54.01	05401	ULTRA SOUND	0	495,568	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	233,616	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	372,240	1,724	0	1,724	58.00
60.00	06000	LABORATORY	0	3,146,128	1,970	25	1,970	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,400,762	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	424,790	598	0	598	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	91,914	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,225,181	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,049,266	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,984,399	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	149,665	0	0	0	74.00
76.00	03950	SLEEP LAB	0	454,342	2,236	7,917	2,236	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	489,819	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,541,047	7,973	70,403	7,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,389,994	76,424,851	145,052	658,822	138,645	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,252	565	0	565	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	41,328	0	0	0	192.00
194.00	07950	MARKETING	0	973,693	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,968	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,013,488	8,936	0	8,936	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)		14,389,994	7,679,091	705,984	1,598,507	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.183336	49.685810	1.071585	10.790079	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		338,003	2,798,968	46,133	362,385	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004306	18.110085	0.070023	2.446134	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	105,767					10.00
11.00	01100	CAFETERIA	0	42,516				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,639	23,225			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	868	0	15,345,482		14.00
15.00	01500	PHARMACY	0	1,361	1,361	43,416	4,525,259	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	797	0	3,520	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,826	7,626	7,626	369,061	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,072	1,367	1,367	125,806	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	19,825	3,541	3,541	265,454	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	15,044	1,677	1,677	175,190	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,292	0	3,290,487	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,023	3,023	533,431	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,532	0	436,158	0	54.00
54.01	05401	ULTRA SOUND	0	484	0	3,044	0	54.01
56.00	05600	RADIOISOTOPE	0	101	0	24,027	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	244	0	17,308	0	58.00
60.00	06000	LABORATORY	0	3,064	0	489,662	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,517	1,517	156,208	0	65.00
66.00	06600	PHYSICAL THERAPY	0	349	0	1,063	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	149	0	559	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,657,302	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,353,696	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,525,259	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	495	495	32,243	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	429	429	66,403	0	90.00
91.00	09100	EMERGENCY	0	2,189	2,189	277,286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	105,767	41,744	23,225	15,321,324	4,525,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9	0	616	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27	0	1,886	0	192.00
194.00	07950	MARKETING	0	220	0	1,708	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	516	0	19,948	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)	1,451,788	1,138,437	2,461,666	1,606,691	1,970,024	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.726285	26.776672	105.992078	0.104701	0.435340	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,774	141,854	92,565	57,273	17,651	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054592	3.336485	3.985576	0.003732	0.003901	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 9:43 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL		5.03
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	668,985,133	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	40,828,365	30.00
31.00	03100	INTENSIVE CARE UNIT	4,120,473	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	25,953,293	31.01
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	7,997,552	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	214,706,144	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,418,670	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,046,332	54.00
54.01	05401	ULTRA SOUND	14,130,997	54.01
56.00	05600	RADIOISOTOPE	3,766,328	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	10,788,303	58.00
60.00	06000	LABORATORY	54,200,548	60.00
65.00	06500	RESPIRATORY THERAPY	8,968,513	65.00
66.00	06600	PHYSICAL THERAPY	2,561,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,434,675	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,103,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,277,925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,294,540	73.00
74.00	07400	RENAL DIALYSIS	706,307	74.00
76.00	03950	SLEEP LAB	3,448,176	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2,682,229	90.00
91.00	09100	EMERGENCY	36,550,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	668,985,133	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	MARKETING	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	194.01
194.02	07952	SENIOR CIRCLE	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	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)	1,408,124	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002105	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,954	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000012	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 9:43 am

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		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	15,723,373		15,723,373	0	15,723,373	30.00
31.00	03100	INTENSIVE CARE UNIT	2,528,634		2,528,634	0	2,528,634	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,813,020		5,813,020	0	5,813,020	31.01
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	2,766,197		2,766,197	0	2,766,197	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,064,175		20,064,175	0	20,064,175	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,640,048		3,640,048	0	3,640,048	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,270,887		4,270,887	0	4,270,887	54.00
54.01	05401	ULTRA SOUND	629,448		629,448	0	629,448	54.01
56.00	05600	RADIOISOTOPE	289,594		289,594	0	289,594	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	575,800		575,800	0	575,800	58.00
60.00	06000	LABORATORY	4,089,495		4,089,495	0	4,089,495	60.00
65.00	06500	RESPIRATORY THERAPY	1,894,216	0	1,894,216	0	1,894,216	65.00
66.00	06600	PHYSICAL THERAPY	553,681	0	553,681	0	553,681	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	120,044		120,044	0	120,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,500,831		5,500,831	0	5,500,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,803,640		7,803,640	0	7,803,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,028,843		8,028,843	0	8,028,843	73.00
74.00	07400	RENAL DIALYSIS	178,591		178,591	0	178,591	74.00
76.00	03950	SLEEP LAB	757,701		757,701	0	757,701	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	649,176		649,176	0	649,176	90.00
91.00	09100	EMERGENCY	3,961,130		3,961,130	0	3,961,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,637,604		2,637,604		2,637,604	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	92,476,128	0	92,476,128	0	92,476,128	200.00
201.00		Less Observation Beds	2,637,604		2,637,604		2,637,604	201.00
202.00		Total (see instructions)	89,838,524	0	89,838,524	0	89,838,524	202.00

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		Cost Center Description	Charges Inpatient	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	27,455,628		27,455,628			30.00
31.00	03100	INTENSIVE CARE UNIT	4,120,473		4,120,473			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	25,953,293		25,953,293			31.01
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	7,997,552		7,997,552			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,493,817	170,212,327	214,706,144	0.093449	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,418,670	0	14,418,670	0.252454	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,704,481	40,341,851	47,046,332	0.090780	0.000000	54.00
54.01	05401	ULTRA SOUND	3,048,507	11,082,490	14,130,997	0.044544	0.000000	54.01
56.00	05600	RADIOISOTOPE	405,149	3,361,179	3,766,328	0.076890	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	622,206	10,166,097	10,788,303	0.053373	0.000000	58.00
60.00	06000	LABORATORY	22,768,175	31,432,373	54,200,548	0.075451	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,509,598	1,458,915	8,968,513	0.211207	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,235,310	326,273	2,561,583	0.216148	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	899,265	2,535,410	3,434,675	0.034951	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,653,291	43,450,605	56,103,896	0.098047	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,927,350	27,350,575	40,277,925	0.193745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,158,729	41,135,811	76,294,540	0.105235	0.000000	73.00
74.00	07400	RENAL DIALYSIS	645,795	60,512	706,307	0.252852	0.000000	74.00
76.00	03950	SLEEP LAB	50,115	3,398,061	3,448,176	0.219740	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,114	2,644,115	2,682,229	0.242029	0.000000	90.00
91.00	09100	EMERGENCY	5,600,411	30,949,873	36,550,284	0.108375	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,111,086	12,261,651	13,372,737	0.197237	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	236,817,015	432,168,118	668,985,133			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	236,817,015	432,168,118	668,985,133			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 9:43 am

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		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
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.093449	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252454	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090780	54.00
54.01	05401	ULTRA SOUND	0.044544	54.01
56.00	05600	RADIOISOTOPE	0.076890	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.053373	58.00
60.00	06000	LABORATORY	0.075451	60.00
65.00	06500	RESPIRATORY THERAPY	0.211207	65.00
66.00	06600	PHYSICAL THERAPY	0.216148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.105235	73.00
74.00	07400	RENAL DIALYSIS	0.252852	74.00
76.00	03950	SLEEP LAB	0.219740	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.242029	90.00
91.00	09100	EMERGENCY	0.108375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.197237	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: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,723,373		15,723,373	0	15,723,373	30.00
31.00	03100	INTENSIVE CARE UNIT	2,528,634		2,528,634	0	2,528,634	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,813,020		5,813,020	0	5,813,020	31.01
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	2,766,197		2,766,197	0	2,766,197	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,064,175		20,064,175	0	20,064,175	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,640,048		3,640,048	0	3,640,048	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,270,887		4,270,887	0	4,270,887	54.00
54.01	05401	ULTRA SOUND	629,448		629,448	0	629,448	54.01
56.00	05600	RADIOISOTOPE	289,594		289,594	0	289,594	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	575,800		575,800	0	575,800	58.00
60.00	06000	LABORATORY	4,089,495		4,089,495	0	4,089,495	60.00
65.00	06500	RESPIRATORY THERAPY	1,894,216	0	1,894,216	0	1,894,216	65.00
66.00	06600	PHYSICAL THERAPY	553,681	0	553,681	0	553,681	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	120,044		120,044	0	120,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,500,831		5,500,831	0	5,500,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,803,640		7,803,640	0	7,803,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,028,843		8,028,843	0	8,028,843	73.00
74.00	07400	RENAL DIALYSIS	178,591		178,591	0	178,591	74.00
76.00	03950	SLEEP LAB	757,701		757,701	0	757,701	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	649,176		649,176	0	649,176	90.00
91.00	09100	EMERGENCY	3,961,130		3,961,130	0	3,961,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,637,604		2,637,604		2,637,604	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	92,476,128	0	92,476,128	0	92,476,128	200.00
201.00		Less Observation Beds	2,637,604		2,637,604		2,637,604	201.00
202.00		Total (see instructions)	89,838,524	0	89,838,524	0	89,838,524	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I | Date/Time Prepared: 8/31/2017 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	27,455,628		27,455,628			30.00
31.00	03100	INTENSIVE CARE UNIT	4,120,473		4,120,473			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	25,953,293		25,953,293			31.01
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	7,997,552		7,997,552			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,493,817	170,212,327	214,706,144	0.093449	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,418,670	0	14,418,670	0.252454	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,704,481	40,341,851	47,046,332	0.090780	0.000000	54.00
54.01	05401	ULTRA SOUND	3,048,507	11,082,490	14,130,997	0.044544	0.000000	54.01
56.00	05600	RADIOISOTOPE	405,149	3,361,179	3,766,328	0.076890	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	622,206	10,166,097	10,788,303	0.053373	0.000000	58.00
60.00	06000	LABORATORY	22,768,175	31,432,373	54,200,548	0.075451	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,509,598	1,458,915	8,968,513	0.211207	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,235,310	326,273	2,561,583	0.216148	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	899,265	2,535,410	3,434,675	0.034951	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,653,291	43,450,605	56,103,896	0.098047	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,927,350	27,350,575	40,277,925	0.193745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,158,729	41,135,811	76,294,540	0.105235	0.000000	73.00
74.00	07400	RENAL DIALYSIS	645,795	60,512	706,307	0.252852	0.000000	74.00
76.00	03950	SLEEP LAB	50,115	3,398,061	3,448,176	0.219740	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,114	2,644,115	2,682,229	0.242029	0.000000	90.00
91.00	09100	EMERGENCY	5,600,411	30,949,873	36,550,284	0.108375	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,111,086	12,261,651	13,372,737	0.197237	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	236,817,015	432,168,118	668,985,133			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	236,817,015	432,168,118	668,985,133			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 9:43 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
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.093449	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252454	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090780	54.00
54.01	05401	ULTRA SOUND	0.044544	54.01
56.00	05600	RADIOISOTOPE	0.076890	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.053373	58.00
60.00	06000	LABORATORY	0.075451	60.00
65.00	06500	RESPIRATORY THERAPY	0.211207	65.00
66.00	06600	PHYSICAL THERAPY	0.216148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.105235	73.00
74.00	07400	RENAL DIALYSIS	0.252852	74.00
76.00	03950	SLEEP LAB	0.219740	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.242029	90.00
91.00	09100	EMERGENCY	0.108375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.197237	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

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

Provider CCN: 15-0150

Period: From 04/01/2016 To 03/31/2017

Worksheet C Part II

Date/Time Prepared: 8/31/2017 9:43 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	20,064,175	3,054,488	17,009,687	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,640,048	44,445	3,595,603	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,270,887	634,010	3,636,877	0	0	54.00
54.01	05401	ULTRA SOUND	629,448	4,221	625,227	0	0	54.01
56.00	05600	RADIOISOTOPE	289,594	1,534	288,060	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	575,800	114,893	460,907	0	0	58.00
60.00	06000	LABORATORY	4,089,495	155,628	3,933,867	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,894,216	18,592	1,875,624	0	0	65.00
66.00	06600	PHYSICAL THERAPY	553,681	42,173	511,508	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	120,044	988	119,056	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,500,831	32,628	5,468,203	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,803,640	46,596	7,757,044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,028,843	40,183	7,988,660	0	0	73.00
74.00	07400	RENAL DIALYSIS	178,591	653	177,938	0	0	74.00
76.00	03950	SLEEP LAB	757,701	151,906	605,795	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	649,176	5,802	643,374	0	0	90.00
91.00	09100	EMERGENCY	3,961,130	552,984	3,408,146	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,637,604	522,652	2,114,952	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	65,644,904	5,424,376	60,220,528	0	0	200.00
201.00		Less Observation Beds	2,637,604	522,652	2,114,952	0	0	201.00
202.00		Total (line 200 minus line 201)	63,007,300	4,901,724	58,105,576	0	0	202.00

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

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part II Date/Time Prepared: 8/31/2017 9:43 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	20,064,175	214,706,144	0.093449	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,640,048	14,418,670	0.252454	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,270,887	47,046,332	0.090780	54.00
54.01	05401	ULTRA SOUND	629,448	14,130,997	0.044544	54.01
56.00	05600	RADIOISOTOPE	289,594	3,766,328	0.076890	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	575,800	10,788,303	0.053373	58.00
60.00	06000	LABORATORY	4,089,495	54,200,548	0.075451	60.00
65.00	06500	RESPIRATORY THERAPY	1,894,216	8,968,513	0.211207	65.00
66.00	06600	PHYSICAL THERAPY	553,681	2,561,583	0.216148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	120,044	3,434,675	0.034951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,500,831	56,103,896	0.098047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,803,640	40,277,925	0.193745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,028,843	76,294,540	0.105235	73.00
74.00	07400	RENAL DIALYSIS	178,591	706,307	0.252852	74.00
76.00	03950	SLEEP LAB	757,701	3,448,176	0.219740	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	649,176	2,682,229	0.242029	90.00
91.00	09100	EMERGENCY	3,961,130	36,550,284	0.108375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,637,604	13,372,737	0.197237	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
200.00		Subtotal (sum of lines 50 thru 199)	65,644,904	603,458,187		200.00
201.00		Less Observation Beds	2,637,604	0		201.00
202.00		Total (line 200 minus line 201)	63,007,300	603,458,187		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part I Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,115,642	0	3,115,642	13,848	224.99	30.00
31.00	INTENSIVE CARE UNIT	458,650		458,650	1,443	317.84	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	679,421		679,421	4,904	138.54	31.01
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	221,848		221,848	4,733	46.87	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	4,475,561		4,475,561	24,928		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,053	461,904	30.00
31.00	INTENSIVE CARE UNIT	359	114,105	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	2,412	576,009	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part II Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,054,488	214,706,144	0.014226	6,100,013	86,779	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,445	14,418,670	0.003082	44,996	139	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	634,010	47,046,332	0.013476	2,061,768	27,784	54.00
54.01	05401	ULTRA SOUND	4,221	14,130,997	0.000299	873,634	261	54.01
56.00	05600	RADIOISOTOPE	1,534	3,766,328	0.000407	128,906	52	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	114,893	10,788,303	0.010650	156,960	1,672	58.00
60.00	06000	LABORATORY	155,628	54,200,548	0.002871	4,845,021	13,910	60.00
65.00	06500	RESPIRATORY THERAPY	18,592	8,968,513	0.002073	1,767,427	3,664	65.00
66.00	06600	PHYSICAL THERAPY	42,173	2,561,583	0.016464	639,683	10,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	988	3,434,675	0.000288	355,419	102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,628	56,103,896	0.000582	2,511,545	1,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,596	40,277,925	0.001157	2,427,111	2,808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,183	76,294,540	0.000527	6,892,419	3,632	73.00
74.00	07400	RENAL DIALYSIS	653	706,307	0.000925	260,103	241	74.00
76.00	03950	SLEEP LAB	151,906	3,448,176	0.044054	15,606	688	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,802	2,682,229	0.002163	11,806	26	90.00
91.00	09100	EMERGENCY	552,984	36,550,284	0.015129	1,776,175	26,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	522,652	13,372,737	0.039083	463,878	18,130	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,424,376	603,458,187		31,332,470	198,754	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part III Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,848	0.00	2,053	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,443	0.00	359	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	4,904	0.00	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	40.00
43.00	04300	NURSERY	4,733	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	24,928		2,412	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	ULTRA SOUND	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	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	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	214,706,144	0.000000	0.000000	6,100,013	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,418,670	0.000000	0.000000	44,996	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,046,332	0.000000	0.000000	2,061,768	54.00
54.01	05401	ULTRA SOUND	0	14,130,997	0.000000	0.000000	873,634	54.01
56.00	05600	RADIOISOTOPE	0	3,766,328	0.000000	0.000000	128,906	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	10,788,303	0.000000	0.000000	156,960	58.00
60.00	06000	LABORATORY	0	54,200,548	0.000000	0.000000	4,845,021	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,968,513	0.000000	0.000000	1,767,427	65.00
66.00	06600	PHYSICAL THERAPY	0	2,561,583	0.000000	0.000000	639,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,434,675	0.000000	0.000000	355,419	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	56,103,896	0.000000	0.000000	2,511,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,277,925	0.000000	0.000000	2,427,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,294,540	0.000000	0.000000	6,892,419	73.00
74.00	07400	RENAL DIALYSIS	0	706,307	0.000000	0.000000	260,103	74.00
76.00	03950	SLEEP LAB	0	3,448,176	0.000000	0.000000	15,606	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,682,229	0.000000	0.000000	11,806	90.00
91.00	09100	EMERGENCY	0	36,550,284	0.000000	0.000000	1,776,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,372,737	0.000000	0.000000	463,878	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	603,458,187			31,332,470	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150

Period: From 04/01/2016 To 03/31/2017

Worksheet D Part IV

Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	27,886,856	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,672,448	0	54.00
54.01	05401	ULTRA SOUND	0	1,656,938	0	54.01
56.00	05600	RADIOISOTOPE	0	915,142	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	1,764,972	0	58.00
60.00	06000	LABORATORY	0	2,949,613	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	271,545	0	65.00
66.00	06600	PHYSICAL THERAPY	0	54,477	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	523,670	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,143,402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,741,004	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,976,809	0	73.00
74.00	07400	RENAL DIALYSIS	0	17,140	0	74.00
76.00	03950	SLEEP LAB	0	599,894	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	763,132	0	90.00
91.00	09100	EMERGENCY	0	3,710,914	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	678,895	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	70,326,851	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093449	27,886,856	0	0	2,605,999	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252454	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090780	6,672,448	0	0	605,725	54.00
54.01	05401	ULTRA SOUND	0.044544	1,656,938	0	0	73,807	54.01
56.00	05600	RADIOISOTOPE	0.076890	915,142	0	0	70,365	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.053373	1,764,972	0	0	94,202	58.00
60.00	06000	LABORATORY	0.075451	2,949,613	0	3,458	222,551	60.00
65.00	06500	RESPIRATORY THERAPY	0.211207	271,545	0	0	57,352	65.00
66.00	06600	PHYSICAL THERAPY	0.216148	54,477	0	0	11,775	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	0.034951	523,670	0	0	18,303	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098047	9,143,402	0	0	896,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193745	6,741,004	0	0	1,306,036	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.105235	5,976,809	0	25,232	628,969	73.00
74.00	07400	RENAL DIALYSIS	0.252852	17,140	0	0	4,334	74.00
76.00	03950	SLEEP LAB	0.219740	599,894	0	0	131,821	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.242029	763,132	0	0	184,700	90.00
91.00	09100	EMERGENCY	0.108375	3,710,914	0	0	402,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.197237	678,895	0	0	133,903	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		70,326,851	0	28,690	7,448,495	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		70,326,851	0	28,690	7,448,495	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		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	ULTRA SOUND	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	261	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	2,655	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	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	2,916	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,916	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part I Date/Time Prepared: 8/31/2017 9:43 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	3,115,642	0	3,115,642	13,848	224.99	30.00
31.00	INTENSIVE CARE UNIT	458,650		458,650	1,443	317.84	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	679,421		679,421	4,904	138.54	31.01
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	221,848		221,848	4,733	46.87	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	4,475,561		4,475,561	24,928		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	295	66,372	30.00
31.00	INTENSIVE CARE UNIT	40	12,714	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	209	28,955	31.01
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	2,119	99,318	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	2,663	207,359	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part II Date/Time Prepared: 8/31/2017 9:43 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	3,054,488	214,706,144	0.014226	598,554	8,515	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,445	14,418,670	0.003082	337,888	1,041	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	634,010	47,046,332	0.013476	195,570	2,636	54.00
54.01	05401	ULTRA SOUND	4,221	14,130,997	0.000299	106,276	32	54.01
56.00	05600	RADIOISOTOPE	1,534	3,766,328	0.000407	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	114,893	10,788,303	0.010650	11,882	127	58.00
60.00	06000	LABORATORY	155,628	54,200,548	0.002871	931,715	2,675	60.00
65.00	06500	RESPIRATORY THERAPY	18,592	8,968,513	0.002073	570,624	1,183	65.00
66.00	06600	PHYSICAL THERAPY	42,173	2,561,583	0.016464	68,772	1,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	988	3,434,675	0.000288	14,114	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,628	56,103,896	0.000582	369,097	215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,596	40,277,925	0.001157	13,175	15	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,183	76,294,540	0.000527	1,345,870	709	73.00
74.00	07400	RENAL DIALYSIS	653	706,307	0.000925	10,814	10	74.00
76.00	03950	SLEEP LAB	151,906	3,448,176	0.044054	2,895	128	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,802	2,682,229	0.002163	0	0	90.00
91.00	09100	EMERGENCY	552,984	36,550,284	0.015129	107,928	1,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	522,652	13,372,737	0.039083	12,023	470	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,424,376	603,458,187		4,697,197	20,525	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part III Date/Time Prepared: 8/31/2017 9:43 am
	Title XIX	Hospital	PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,848	0.00	295	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,443	0.00	40	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	4,904	0.00	209	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	40.00
43.00	04300	NURSERY	4,733	0.00	2,119	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	24,928		2,663	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	ULTRA SOUND	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	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	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	214,706,144	0.000000	0.000000	598,554	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,418,670	0.000000	0.000000	337,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,046,332	0.000000	0.000000	195,570	54.00
54.01	05401	ULTRA SOUND	0	14,130,997	0.000000	0.000000	106,276	54.01
56.00	05600	RADIOISOTOPE	0	3,766,328	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	10,788,303	0.000000	0.000000	11,882	58.00
60.00	06000	LABORATORY	0	54,200,548	0.000000	0.000000	931,715	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,968,513	0.000000	0.000000	570,624	65.00
66.00	06600	PHYSICAL THERAPY	0	2,561,583	0.000000	0.000000	68,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,434,675	0.000000	0.000000	14,114	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	56,103,896	0.000000	0.000000	369,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,277,925	0.000000	0.000000	13,175	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,294,540	0.000000	0.000000	1,345,870	73.00
74.00	07400	RENAL DIALYSIS	0	706,307	0.000000	0.000000	10,814	74.00
76.00	03950	SLEEP LAB	0	3,448,176	0.000000	0.000000	2,895	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,682,229	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	36,550,284	0.000000	0.000000	107,928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,372,737	0.000000	0.000000	12,023	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	603,458,187			4,697,197	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 9:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/31/2017 9:43 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	0.093449	0	0	824,736	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252454	0	0	24,566	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090780	0	0	443,763	0	54.00
54.01	05401	ULTRA SOUND	0.044544	0	0	143,814	0	54.01
56.00	05600	RADIOISOTOPE	0.076890	0	0	23,802	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.053373	0	0	65,749	0	58.00
60.00	06000	LABORATORY	0.075451	0	0	389,556	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.211207	0	0	11,426	0	65.00
66.00	06600	PHYSICAL THERAPY	0.216148	0	0	2,352	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	0.034951	0	0	22,739	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098047	0	0	136,217	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193745	0	0	113,134	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.105235	0	0	497,070	0	73.00
74.00	07400	RENAL DIALYSIS	0.252852	0	0	11,057	0	74.00
76.00	03950	SLEEP LAB	0.219740	0	0	57,466	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.242029	0	0	18,588	0	90.00
91.00	09100	EMERGENCY	0.108375	0	0	706,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.197237	0	0	108,971	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	3,601,077	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	3,601,077	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/31/2017 9:43 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	0	77,071	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,202	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,285	54.00
54.01	05401	ULTRA SOUND	0	6,406	54.01
56.00	05600	RADIOISOTOPE	0	1,830	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	3,509	58.00
60.00	06000	LABORATORY	0	29,392	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,413	65.00
66.00	06600	PHYSICAL THERAPY	0	508	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	795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,309	73.00
74.00	07400	RENAL DIALYSIS	0	2,796	74.00
76.00	03950	SLEEP LAB	0	12,628	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	4,499	90.00
91.00	09100	EMERGENCY	0	76,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	21,493	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	373,931	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	373,931	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/31/2017 9:43 am

	Title XVIII	Hospital	PPS	

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,848	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,848	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,525	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,053	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,723,373	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,723,373	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)	15,723,373	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)	1,135.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,331,038	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)	2,331,038	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,528,634	1,443	1,752.35	359	629,094	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	5,813,020	4,904	1,185.36	0	0	43.01
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)	3,513,168	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,473,300	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)	576,009	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	198,754	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	774,763	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,698,537	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)	2,323	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,135.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,637,604	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,115,642	15,723,373	0.198154	2,637,604	522,652	90.00
91.00	Nursing School cost	0	15,723,373	0.000000	2,637,604	0	91.00
92.00	Allied health cost	0	15,723,373	0.000000	2,637,604	0	92.00
93.00	All other Medical Education	0	15,723,373	0.000000	2,637,604	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/31/2017 9:43 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)	13,848	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,848	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,525	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	295	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)	4,733	15.00
16.00	Nursery days (title V or XIX only)	2,119	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,723,373	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,723,373	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)	15,723,373	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)	1,135.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	334,952	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)	334,952	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/31/2017 9:43 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)	2,766,197	4,733	584.45	2,119	1,238,450	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,528,634	1,443	1,752.35	40	70,094	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	5,813,020	4,904	1,185.36	209	247,740	43.01
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)	568,347	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,459,583	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)	207,359	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	20,525	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	227,884	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,231,699	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)	2,323	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,135.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,637,604	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/31/2017 9:43 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	3,115,642	15,723,373	0.198154	2,637,604	522,652	90.00
91.00	Nursing School cost	0	15,723,373	0.000000	2,637,604	0	91.00
92.00	Allied health cost	0	15,723,373	0.000000	2,637,604	0	92.00
93.00	All other Medical Education	0	15,723,373	0.000000	2,637,604	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet D-3 Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,403,083		30.00
31.00	03100	INTENSIVE CARE UNIT		1,645,138		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093449	6,100,013	570,040	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252454	44,996	11,359	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090780	2,061,768	187,167	54.00
54.01	05401	ULTRA SOUND	0.044544	873,634	38,915	54.01
56.00	05600	RADIOISOTOPE	0.076890	128,906	9,912	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.053373	156,960	8,377	58.00
60.00	06000	LABORATORY	0.075451	4,845,021	365,562	60.00
65.00	06500	RESPIRATORY THERAPY	0.211207	1,767,427	373,293	65.00
66.00	06600	PHYSICAL THERAPY	0.216148	639,683	138,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034951	355,419	12,422	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098047	2,511,545	246,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193745	2,427,111	470,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.105235	6,892,419	725,324	73.00
74.00	07400	RENAL DIALYSIS	0.252852	260,103	65,768	74.00
76.00	03950	SLEEP LAB	0.219740	15,606	3,429	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.242029	11,806	2,857	90.00
91.00	09100	EMERGENCY	0.108375	1,776,175	192,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.197237	463,878	91,494	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		31,332,470	3,513,168	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)		31,332,470		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/31/2017 9:43 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		679,592		30.00
31.00	03100	INTENSIVE CARE UNIT		141,530		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		2,512,606		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		402,998		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093449	598,554	55,934	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252454	337,888	85,301	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090780	195,570	17,754	54.00
54.01	05401	ULTRA SOUND	0.044544	106,276	4,734	54.01
56.00	05600	RADIOISOTOPE	0.076890	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.053373	11,882	634	58.00
60.00	06000	LABORATORY	0.075451	931,715	70,299	60.00
65.00	06500	RESPIRATORY THERAPY	0.211207	570,624	120,520	65.00
66.00	06600	PHYSICAL THERAPY	0.216148	68,772	14,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034951	14,114	493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.098047	369,097	36,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193745	13,175	2,553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.105235	1,345,870	141,633	73.00
74.00	07400	RENAL DIALYSIS	0.252852	10,814	2,734	74.00
76.00	03950	SLEEP LAB	0.219740	2,895	636	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.242029	0	0	90.00
91.00	09100	EMERGENCY	0.108375	107,928	11,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.197237	12,023	2,371	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,697,197	568,347	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,697,197		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,396,393	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,447,351	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	49,852	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	3,775,159	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	124.64	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.51	30.00
31.00	Percentage of Medicaid patient days (see instructions)	33.10	31.00
32.00	Sum of lines 30 and 31	37.61	32.00
33.00	Allowable disproportionate share percentage (see instructions)	20.24	33.00
34.00	Disproportionate share adjustment (see instructions)	245,094	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000177496	0.000170447	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,137,064	1,018,846	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	568,532	508,027	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,076,559		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,215,249		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,215,249	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	428,267	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,643,516	59.00
60.00	Primary payer payments	2,397	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,641,119	61.00
62.00	Deductibles billed to program beneficiaries	641,004	62.00
63.00	Coinsurance billed to program beneficiaries	966	63.00
64.00	Allowable bad debts (see instructions)	63,446	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	41,240	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	46,163	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,040,389	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	21,640	70.93
70.94	HRR adjustment amount (see instructions)	-3,870	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E Part A Date/Time Prepared: 8/31/2017 9:43 am

		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		33,510	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,024,649	71.00
71.01	Sequestration adjustment (see instructions)		120,493	71.01
72.00	Interim payments		5,992,792	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-88,636	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		808,746	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,396,393	2,396,393		2,396,393	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,447,351		2,447,351	2,447,351	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	49,852	43,929	5,923	49,852	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,775,159	1,887,579	1,887,580	3,775,159	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2024	0.2024	0.2024		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	245,094	121,258	123,836	245,094	11.00
11.01	Uncompensated care payments	36.00	1,076,559	568,532	508,027	1,076,559	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,215,249	3,130,112	3,085,137	6,215,249	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,215,249	3,130,112	3,085,137	6,215,249	15.00
16.00	Payment for inpatient program capital	50.00	428,267	214,956	213,311	428,267	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,345,068	3,298,448	6,643,516	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/31/2017 9:43 am

		Title XVIII		Hospital	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	386,705	190,403	196,302	386,705	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	10,935	9,473	1,462	10,935	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0792	0.0792	0.0792		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	30,627	15,080	15,547	30,627	25.00
26.00	Total prospective capital payments (see instructions)	12.00	428,267	214,956	213,311	428,267	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	21,640	8,070	13,570	21,640	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-3,870	-2,157	-1,713	-3,870	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		33,510	0	33,510	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part B Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,916	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,448,495	2.00
3.00	PPS payments	7,158,016	3.00
4.00	Outlier payment (see instructions)	171,048	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,916	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	28,690	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)	28,690	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)	28,690	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	25,774	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,916	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	7,329,064	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	3,297	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,307,445	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)	6,021,238	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)	6,021,238	30.00
31.00	Primary payer payments	2,190	31.00
32.00	Subtotal (line 30 minus line 31)	6,019,048	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)	214,928	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	139,703	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	165,873	36.00
37.00	Subtotal (see instructions)	6,158,751	37.00
38.00	MSP-LCC reconciliation amount from PS&R	14	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,158,737	40.00
40.01	Sequestration adjustment (see instructions)	123,175	40.01
41.00	Interim payments	6,095,819	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-60,257	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: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 8/31/2017 9:43 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,919,792		5,897,383	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		38,200		144,836	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/07/2016	34,800	10/07/2016	53,600	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)		34,800		53,600	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)		5,992,792		6,095,819	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		88,636		60,257	6.02
7.00	Total Medicare program liability (see instructions)		5,904,156		6,035,562	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: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet E-1 Part II Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	6,166	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,412	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,534	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	17,872	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	668,985,133	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,484,351	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 8/31/2017 9:43 am
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		373,931	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	373,931	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	373,931	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,264,439		8.00
9.00	Ancillary service charges	4,697,197	3,601,077	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,961,636	3,601,077	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,961,636	3,601,077	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,961,636	3,227,146	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	373,931	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	373,931	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	373,931	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	373,931	36.00
37.00	ELIMINATE SETTLEMENT	0	-373,931	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G | Date/Time Prepared: 8/31/2017 9:43 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	-354,417	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	25,428,441	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	2,396,369	0	0	0	6.00
7.00	Inventory	3,824,769	0	0	0	7.00
8.00	Prepaid expenses	1,451,213	0	0	0	8.00
9.00	Other current assets	353,642	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)	33,100,017	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,060,000	0	0	0	12.00
13.00	Land improvements	629,378	0	0	0	13.00
14.00	Accumulated depreciation	-336,758	0	0	0	14.00
15.00	Buildings	63,592,652	0	0	0	15.00
16.00	Accumulated depreciation	-12,401,390	0	0	0	16.00
17.00	Leasehold improvements	4,300,813	0	0	0	17.00
18.00	Accumulated depreciation	-843,479	0	0	0	18.00
19.00	Fixed equipment	1,962,165	0	0	0	19.00
20.00	Accumulated depreciation	-1,339,767	0	0	0	20.00
21.00	Automobiles and trucks	24,168	0	0	0	21.00
22.00	Accumulated depreciation	-11,369	0	0	0	22.00
23.00	Major movable equipment	34,789,787	0	0	0	23.00
24.00	Accumulated depreciation	-27,014,869	0	0	0	24.00
25.00	Minor equipment depreciable	7,301,474	0	0	0	25.00
26.00	Accumulated depreciation	-6,249,602	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)	65,463,203	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	5,683,360	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,683,360	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	104,246,580	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,498,885	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,709,049	0	0	0	38.00
39.00	Payroll taxes payable	22,734	0	0	0	39.00
40.00	Notes and loans payable (short term)	419,488	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	-289,072,564	0	0	0	43.00
44.00	Other current liabilities	1,752,741	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-279,669,667	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,474,707	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	44,033,990	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	45,508,697	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-234,160,970	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	338,407,550				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)	338,407,550	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	104,246,580	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0150

Period: From 04/01/2016 To 03/31/2017

Worksheet G-1

Date/Time Prepared: 8/31/2017 9:43 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		298,699,744		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		39,707,805				2.00
3.00	Total (sum of line 1 and line 2)		338,407,549		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)		338,407,549		0		11.00
12.00	ROUNDING	6		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)		6		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		338,407,543		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2017 9:43 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	35,453,180		35,453,180	1.00
2.00	SUBPROVIDER - IPF	0		0	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	0		0	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)	35,453,180		35,453,180	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,120,473		4,120,473	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	25,953,293		25,953,293	11.01
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)	30,073,766		30,073,766	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	65,526,946		65,526,946	17.00
18.00	Ancillary services	164,540,458	386,312,479	550,852,937	18.00
19.00	Outpatient services	6,749,611	45,855,639	52,605,250	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)	236,817,015	432,168,118	668,985,133	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		114,175,213		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)		114,175,213		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet G-3 Date/Time Prepared: 8/31/2017 9:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	668,985,133	1.00
2.00	Less contractual allowances and discounts on patients' accounts	516,245,732	2.00
3.00	Net patient revenues (line 1 minus line 2)	152,739,401	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	114,175,213	4.00
5.00	Net income from service to patients (line 3 minus line 4)	38,564,188	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 MISCELLANEOUS REVENUE	1,143,617	24.00
25.00	Total other income (sum of lines 6-24)	1,143,617	25.00
26.00	Total (line 5 plus line 25)	39,707,805	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)	39,707,805	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0150	Period: From 04/01/2016 To 03/31/2017	Worksheet L Parts I-III Date/Time Prepared: 8/31/2017 9:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	386,705	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	10,935	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	51.65	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	4.51	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	33.10	8.00
9.00	Sum of lines 7 and 8	37.61	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.92	10.00
11.00	Disproportionate share adjustment (see instructions)	30,627	11.00
12.00	Total prospective capital payments (see instructions)	428,267	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00