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: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/31/2018 3:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2018 Time: 3:18 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH CRAWFORDSVILLE (15-0022) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII 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	52,299	-8,554	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	52,299	-8,554	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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 3:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1710 LAFAYETTE RD.	PO Box:			1.00
2.00	City: CRAWFORDSVILLE	State: IN	Zip Code: 47933	County: MONTGOMERY	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	FRANCISCAN HEALTH CRAWFORDSVILLE	150022	99915	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	FRANCISCAN HEALTH CRAWFORDSVILLE PSY	15S022	99915	4	01/01/1995	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 3:17 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2017	12/31/2017	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 3:17 am

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

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 3:17 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 3:17 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 3:17 am

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

		1.00	2.00	3.00	
	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	249,380	53,125	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 3:17 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	143.00

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

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

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

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

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

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

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

		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)	08/05/2017	11/03/2017	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2018 3:17 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.	Y	A	01/01/2017	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.	Y	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	04/11/2018	Y	04/11/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 3:17 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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927	STEVEN.HOWELL@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 3:17 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 REIMBURSEMENT		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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 3:17 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	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)		24	8,760	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		29	10,585	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	11	4,015		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 3:17 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,640	34	2,696			1.00
2.00	HMO and other (see instructions)	617	109				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)	1,640	34	2,696			7.00
8.00	INTENSIVE CARE UNIT	251	48	500			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,891	82	3,196	0.00	149.59	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,961	0	2,241	0.00	12.89	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	162.48	27.00
28.00	Observation Bed Days		145	1,102			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 3:17 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	642	12	1,109	1.00
2.00	HMO and other (see instructions)			202	59		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	642	12	1,109	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	148	0	176	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 3:17 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	10,469,898	637,297	11,107,195	333,972.36	33.26	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,045,200	0	1,045,200	28,685.00	36.44	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		502,667	0	502,667	7,549.81	66.58	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		2,984,413	0	2,984,413	93,452.00	31.94	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)		3,219,680	0	3,219,680			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		335,468	0	335,468			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,347,093	0	1,347,093			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	135,526	135,526	0.00	0.00	26.00
27.00	Administrative & General	5.00	364,392	317,510	681,902	6,690.89	101.91	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 3:17 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		81,871	0	81,871	861.00	95.09	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	185,214	0	185,214	7,161.00	25.86	30.00
31.00	Laundry & Linen Service	8.00	142,494	0	142,494	8,660.00	16.45	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		500,065	0	500,065	28,493.73	17.55	33.00
34.00	Dietary	10.00	349,339	-178,139	171,200	10,023.57	17.08	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	178,139	178,139	10,429.52	17.08	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	11,457	184,261	195,718	4,360.37	44.89	38.00
39.00	Central Services and Supply	14.00	65,743	0	65,743	2,433.50	27.02	39.00
40.00	Pharmacy	15.00	428,874	0	428,874	9,339.82	45.92	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2018 3:17 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)		11,051,834	637,297	11,689,131	363,327.09	32.17	1.00
2.00	Excluded area salaries (see instructions)		1,045,200	0	1,045,200	28,685.00	36.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)		10,006,634	637,297	10,643,931	334,642.09	31.81	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,487,080	0	3,487,080	101,001.81	34.52	4.00
5.00	Subtotal wage-related costs (see inst.)		4,566,773	0	4,566,773	0.00	42.90	5.00
6.00	Total (sum of lines 3 thru 5)		18,060,487	637,297	18,697,784	435,643.90	42.92	6.00
7.00	Total overhead cost (see instructions)		2,129,449	637,297	2,766,746	88,453.40	31.28	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2018 3:17 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	886,909	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,878,407	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	128,285	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	30,044	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-118,140	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	749,643	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	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)	3,555,148	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2018 3:17 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	502,667	3,555,148	1.00
2.00	Hospital	502,667	3,555,148	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			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			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/31/2018 3:17 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)	0.232299	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,875,245	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	27,163,945	6.00
7.00	Medicaid cost (line 1 times line 6)	6,310,157	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,434,912	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,434,912	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,409,282	0	7,409,282	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,721,169	0	1,721,169	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,721,169	0	1,721,169	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	402,613	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	184,141	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	283,295	27.01
28.00	Non-Medicare bad debt expense (see instructions)	119,318	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	126,871	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,848,040	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,282,952	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 3:17 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		3,637,604	3,637,604	1,165,696	4,803,300	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		65,177	65,177	0	65,177	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,527,417	3,527,417	0	3,527,417	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	364,392	12,312,136	12,676,528	-1,142,963	11,533,565	5.00
7.00	00700	OPERATION OF PLANT	185,214	1,330,436	1,515,650	-7,749	1,507,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,494	31,251	173,745	-2,545	171,200	8.00
9.00	00900	HOUSEKEEPING	0	531,197	531,197	-16,508	514,689	9.00
10.00	01000	DIETARY	349,339	210,610	559,949	-288,028	271,921	10.00
11.00	01100	CAFETERIA	0	0	0	283,252	283,252	11.00
13.00	01300	NURSING ADMINISTRATION	11,457	168,498	179,955	-1,567	178,388	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,743	319,208	384,951	-70,508	314,443	14.00
15.00	01500	PHARMACY	428,874	1,071,622	1,500,496	-978,061	522,435	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,426,189	121,599	1,547,788	-58,679	1,489,109	30.00
31.00	03100	INTENSIVE CARE UNIT	696,744	196,173	892,917	-16,934	875,983	31.00
40.00	04000	SUBPROVIDER - IPF	999,496	43,078	1,042,574	-10,970	1,031,604	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,407,460	1,400,947	2,808,407	-1,109,260	1,699,147	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,075,194	675,777	1,750,971	-83,393	1,667,578	54.00
54.01	05401	ULTRASOUND	94,161	4,171	98,332	0	98,332	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	476,945	7,340,900	7,817,845	-6,776,942	1,040,903	55.00
56.00	05600	RADIOISOTOPE	80,660	156,850	237,510	-89,030	148,480	56.00
60.00	06000	LABORATORY	0	2,175,443	2,175,443	0	2,175,443	60.00
65.00	06500	RESPIRATORY THERAPY	300,051	52,773	352,824	-14,548	338,276	65.00
66.00	06600	PHYSICAL THERAPY	500,702	8,866	509,568	-4,405	505,163	66.00
69.00	06900	ELECTROCARDIOLOGY	230,811	19,720	250,531	-11,197	239,334	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,161,694	1,161,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	464,892	464,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,823,685	7,823,685	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	21,437	21,437	0	21,437	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	139,071	29,605	168,676	-3,437	165,239	90.00
91.00	09100	EMERGENCY	1,449,197	750,749	2,199,946	-212,240	1,987,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,424,194	36,203,244	46,627,438	255	46,627,693	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,439	2,661,729	2,689,168	-255	2,688,913	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	18,265	0	18,265	0	18,265	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	10,469,898	38,864,973	49,334,871	0	49,334,871	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 3:17 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	2,100,866	6,904,166		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	65,177		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-100	3,527,317		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,608,457	6,925,108		5.00
7.00	00700	OPERATION OF PLANT	0	1,507,901		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-15,778	155,422		8.00
9.00	00900	HOUSEKEEPING	0	514,689		9.00
10.00	01000	DIETARY	-51,964	219,957		10.00
11.00	01100	CAFETERIA	-93,222	190,030		11.00
13.00	01300	NURSING ADMINISTRATION	193,360	371,748		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-199,632	114,811		14.00
15.00	01500	PHARMACY	4,835	527,270		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	409,265	409,265		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-8,890	1,480,219		30.00
31.00	03100	INTENSIVE CARE UNIT	0	875,983		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,031,604		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-129,112	1,570,035		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,828	1,658,750		54.00
54.01	05401	ULTRASOUND	0	98,332		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-205,950	834,953		55.00
56.00	05600	RADIOISOTOPE	0	148,480		56.00
60.00	06000	LABORATORY	-24,670	2,150,773		60.00
65.00	06500	RESPIRATORY THERAPY	0	338,276		65.00
66.00	06600	PHYSICAL THERAPY	-23,550	481,613		66.00
69.00	06900	ELECTROCARDIOLOGY	-1,855	237,479		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,161,694		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	464,892		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,823,685		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	21,437		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	165,239		90.00
91.00	09100	EMERGENCY	-1,820	1,985,886		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,665,502	43,962,191		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,688,913		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0		194.01
194.02	07952	COMMUNITY IND HEALTH	0	18,265		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,665,502	46,669,369		200.00

RECLASSIFICATIONS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 3:17 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,769	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	6,021	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	137	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
	0		0	37,927	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,133,927	1.00
	0		0	1,133,927	
	C - DIETARY				
1.00	CAFETERIA	11.00	178,139	106,277	1.00
	0		178,139	106,277	
	D - CHARGEABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,161,694	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	1,161,694	
	E - DRUGS CHARGEABLE TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,823,685	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
	0		0	7,823,685	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	464,892	1.00
2.00		0.00	0	0	2.00
	0		0	464,892	
	G - FSEH SHARED SERVICES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	169,445	33,919	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	317,510	0	2.00
3.00	NURSING ADMINISTRATION	13.00	184,261	0	3.00
	0		671,216	33,919	
500.00	Grand Total: Increases		849,355	10,762,321	500.00

RECLASSIFICATIONS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 3:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL						
1.00	OPERATION OF PLANT	7.00	0	6,679	9		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	337	0		2.00
3.00	DIETARY	10.00	0	2,196	0		3.00
4.00	PHARMACY	15.00	0	435	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	710	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	786	0		6.00
7.00	OPERATING ROOM	50.00	0	16,709	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,352	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	232	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	70	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	184	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	2,112	0		12.00
13.00	EMERGENCY	91.00	0	5,915	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	210	0		14.00
	0		0	37,927			
	B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,133,927	11		1.00
	0		0	1,133,927			
	C - DIETARY						
1.00	DIETARY	10.00	178,139	106,277	0		1.00
	0		178,139	106,277			
	D - CHARGEABLE SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,998	0		1.00
2.00	OPERATION OF PLANT	7.00	0	865	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	2,208	0		3.00
4.00	HOUSEKEEPING	9.00	0	16,508	0		4.00
5.00	DIETARY	10.00	0	1,416	0		5.00
6.00	CAFETERIA	11.00	0	1,164	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	1,567	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	69,571	0		8.00
9.00	PHARMACY	15.00	0	35,388	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	58,050	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	16,098	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	10,177	0		12.00
13.00	OPERATING ROOM	50.00	0	625,863	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	78,028	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,366	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	14,478	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	4,213	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	9,018	0		18.00
19.00	CLINIC	90.00	0	3,399	0		19.00
20.00	EMERGENCY	91.00	0	200,274	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	45	0		21.00
	0		0	1,161,694			
	E - DRUGS CHARGEABLE TO PATIENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,059	0		1.00
2.00	OPERATION OF PLANT	7.00	0	205	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	937	0		3.00
4.00	PHARMACY	15.00	0	942,238	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	766	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	126	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	7	0		7.00
8.00	OPERATING ROOM	50.00	0	5,380	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,013	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	6,772,344	0		10.00
11.00	RADIOISOTOPE	56.00	0	89,030	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	8	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	67	0		13.00
14.00	CLINIC	90.00	0	38	0		14.00
15.00	EMERGENCY	91.00	0	2,467	0		15.00
	0		0	7,823,685			
	F - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	461,308	0		1.00
2.00	EMERGENCY	91.00	0	3,584	0		2.00
	0		0	464,892			
	G - FSEH SHARED SERVICES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	33,919	169,445	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	317,510	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	184,261	0		3.00
	0		33,919	671,216			
500.00	Grand Total: Decreases		212,058	11,399,618			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2018 3:17 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	970,120	0	0	0	0	1.00
2.00	Land Improvements	3,186,248	609,380	0	609,380	0	2.00
3.00	Buildings and Fixtures	31,291,418	8,522,448	0	8,522,448	0	3.00
4.00	Building Improvements	507,274	0	0	0	0	4.00
5.00	Fixed Equipment	19,623	0	0	0	0	5.00
6.00	Movable Equipment	20,101,622	449,198	0	449,198	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,076,305	9,581,026	0	9,581,026	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	56,076,305	9,581,026	0	9,581,026	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	970,120	0	1.00
2.00	Land Improvements	3,795,628	0	2.00
3.00	Buildings and Fixtures	39,813,866	0	3.00
4.00	Building Improvements	507,274	0	4.00
5.00	Fixed Equipment	19,623	0	5.00
6.00	Movable Equipment	20,550,820	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,657,331	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,657,331	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2018 3:17 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	3,011,392	626,212	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	65,177	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,011,392	691,389	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	3,637,604	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	65,177	2.00
3.00	Total (sum of lines 1-2)	0	3,702,781	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2018 3:17 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	3,637,604	0	3,637,604	0.982398	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,177	0	65,177	0.017602	0	2.00
3.00	Total (sum of lines 1-2)	3,702,781	0	3,702,781	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	3,719,984	2,055,747	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	65,177	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,719,984	2,120,924	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	1,128,435	0	0	0	6,904,166	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	65,177	2.00
3.00	Total (sum of lines 1-2)	1,128,435	0	0	0	6,969,343	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 3:17 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)	B	-5,492	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-194,783	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-364,247			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	968,276			0	12.00
13.00	Laundry and linen service	B	-15,778	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-93,222	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-26,841	ADMINISTRATIVE & GENERAL	5.00	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	-1,172	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-5,810	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-15,200	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 3:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-46,106	DIETARY	10.00	0	33.01
33.02	MISC INCOME	B	-245	ELECTROCARDIOLOGY	69.00	0	33.02
33.03	MISC INCOME	B	-23,550	PHYSICAL THERAPY	66.00	0	33.03
33.04	MISC INCOME	B	-3,227	RADIOLOGY-THERAPEUTIC	55.00	0	33.04
33.05	MISC INCOME	B	-370	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISC INCOME	B	-48	DIETARY	10.00	0	33.06
33.07	ADVERTISING EXPENSE	A	-176	RADIOLOGY-THERAPEUTIC	55.00	0	33.07
33.08	HAF ASSESSMENT	A	-1,687,677	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PENSION ADJ	A	195,000	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	INTEREST EXPENSE	A	-1,340,397	ADMINISTRATIVE & GENERAL	5.00	11	33.10
33.11	MISC INCOME	B	-4,337	PHARMACY	15.00	0	33.11
33.12	MISC INCOME	B	-100	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,665,502				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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 3:17 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	FA-INT	2,692,167	1,262,632	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	676,823	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	5,781,151	7,888,971	3.00
4.00	15.00	PHARMACY	FA-COEP	75,532	66,360	4.00
4.01	30.00	ADULTS & PEDIATRICS	FA-AIS	0	8,890	4.01
4.02	50.00	OPERATING ROOM	FA-AIS	0	910	4.02
4.03	69.00	ELECTROCARDIOLOGY	FA-AIS	0	1,610	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	FA - HIM	409,265	0	4.04
4.05	91.00	EMERGENCY	FA-AIS	0	1,820	4.05
4.06	14.00	CENTRAL SERVICES & SUPPLY	FA - SUPPLIES	0	199,632	4.06
4.08	5.00	ADMINISTRATIVE & GENERAL	FSEH SHARED SERVICE	570,803	0	4.08
4.09	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICE	193,360	0	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,399,101	9,430,825	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.

6.00	B	FRANCISCAN ALLI	100.00	FRANCISCAN ALLI	100.00	6.00
7.00	G	FSEH	100.00	FSEH	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 3:17 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	1,429,535	10		1.00
2.00	676,823	9		2.00
3.00	-2,107,820	0		3.00
4.00	9,172	0		4.00
4.01	-8,890	0		4.01
4.02	-910	0		4.02
4.03	-1,610	0		4.03
4.04	409,265	0		4.04
4.05	-1,820	0		4.05
4.06	-199,632	0		4.06
4.08	570,803	0		4.08
4.09	193,360	0		4.09
5.00	968,276			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	SISTER FACILITY		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2018 3:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	128,202	128,202	0	246,400	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	8,828	8,828	0	271,900	0	2.00
3.00	55.00	RADIOLOGY-THERAPEUTIC	202,547	202,547	0	211,500	0	3.00
4.00	60.00	LABORATORY	24,670	24,670	0	211,500	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			364,247	364,247	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	128,202		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	8,828		2.00
3.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	202,547		3.00
4.00	60.00	LABORATORY	0	0	0	24,670		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	364,247		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,904,166	6,904,166				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	65,177		65,177			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,527,317	45,162	426	3,572,905		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,925,108	980,447	9,256	222,060	8,136,871	5.00
7.00	00700	OPERATION OF PLANT	1,507,901	496,220	4,684	60,315	2,069,120	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	155,422	193,266	1,824	46,403	396,915	8.00
9.00	00900	HOUSEKEEPING	514,689	15,429	146	0	530,264	9.00
10.00	01000	DIETARY	219,957	192,454	1,817	55,751	469,979	10.00
11.00	01100	CAFETERIA	190,030	105,565	997	58,011	354,603	11.00
13.00	01300	NURSING ADMINISTRATION	371,748	63,277	597	63,735	499,357	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,811	353,613	3,338	21,409	493,171	14.00
15.00	01500	PHARMACY	527,270	18,739	177	139,662	685,848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	409,265	120,869	1,141	0	531,275	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,480,219	982,447	9,275	464,436	2,936,377	30.00
31.00	03100	INTENSIVE CARE UNIT	875,983	117,371	1,108	226,893	1,221,355	31.00
40.00	04000	SUBPROVIDER - IPF	1,031,604	269,223	2,542	325,484	1,628,853	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,570,035	391,841	3,699	458,337	2,423,912	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,658,750	966,829	9,127	350,135	2,984,841	54.00
54.01	05401	ULTRASOUND	98,332	17,553	166	30,663	146,714	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	834,953	0	0	155,316	990,269	55.00
56.00	05600	RADIOISOTOPE	148,480	16,678	157	26,267	191,582	56.00
60.00	06000	LABORATORY	2,150,773	336,435	3,176	0	2,490,384	60.00
65.00	06500	RESPIRATORY THERAPY	338,276	25,361	239	97,711	461,587	65.00
66.00	06600	PHYSICAL THERAPY	481,613	145,480	1,373	163,053	791,519	66.00
69.00	06900	ELECTROCARDIOLOGY	237,479	20,176	190	75,163	333,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,161,694	88,200	833	0	1,250,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	464,892	0	0	0	464,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,823,685	266,787	2,519	0	8,092,991	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	21,437	0	0	0	21,437	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	165,239	53,157	502	45,288	264,186	90.00
91.00	09100	EMERGENCY	1,985,886	392,404	3,704	471,930	2,853,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,962,191	6,674,983	63,013	3,558,022	43,715,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,925	207	0	22,132	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,688,913	0	0	8,935	2,697,848	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	105,815	999	0	106,814	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	18,265	101,443	958	5,948	126,614	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,669,369	6,904,166	65,177	3,572,905	46,669,369	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,136,871					5.00
7.00	00700	OPERATION OF PLANT	436,934	2,506,054				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,816	89,986	570,717			8.00
9.00	00900	HOUSEKEEPING	111,975	7,184	63,272	712,695		9.00
10.00	01000	DIETARY	99,245	89,608	3,835	26,511	689,178	10.00
11.00	01100	CAFETERIA	74,881	49,152	0	14,542	0	11.00
13.00	01300	NURSING ADMINISTRATION	105,449	29,462	0	8,717	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,142	164,645	2,106	48,712	0	14.00
15.00	01500	PHARMACY	144,830	8,725	0	2,581	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,189	56,278	0	16,650	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	620,072	457,432	173,072	135,337	341,733	30.00
31.00	03100	INTENSIVE CARE UNIT	257,912	54,649	16,232	16,168	63,388	31.00
40.00	04000	SUBPROVIDER - IPF	343,963	125,352	53,237	37,087	284,057	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	511,855	182,444	76,247	53,978	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,306	450,163	21,215	133,186	0	54.00
54.01	05401	ULTRASOUND	30,981	8,173	0	2,418	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	209,114	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	40,456	7,765	0	2,297	0	56.00
60.00	06000	LABORATORY	525,892	156,647	0	46,346	0	60.00
65.00	06500	RESPIRATORY THERAPY	97,473	11,808	2,939	3,494	0	65.00
66.00	06600	PHYSICAL THERAPY	167,144	67,737	14,828	20,041	0	66.00
69.00	06900	ELECTROCARDIOLOGY	70,321	9,394	0	2,779	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	264,115	41,067	0	12,150	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,171	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,708,991	124,218	0	36,751	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,527	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,788	24,751	0	7,323	0	90.00
91.00	09100	EMERGENCY	602,660	182,706	143,734	54,056	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,513,202	2,399,346	570,717	681,124	689,178	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,674	10,208	0	3,020	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	569,702	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	22,556	49,268	0	14,577	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	26,737	47,232	0	13,974	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,136,871	2,506,054	570,717	712,695	689,178	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	493,178					11.00
13.00	01300	NURSING ADMINISTRATION	639	643,624				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,151	5,424	822,351			14.00
15.00	01500	PHARMACY	15,930	20,818	0	878,732		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	716,392	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,022	100,638	0	0	25,170	30.00
31.00	03100	INTENSIVE CARE UNIT	31,788	41,562	0	0	7,211	31.00
40.00	04000	SUBPROVIDER - IPF	45,731	59,751	0	0	17,095	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,497	98,659	0	0	39,772	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,119	74,621	0	0	149,821	54.00
54.01	05401	ULTRASOUND	4,506	5,883	0	0	12,308	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	34,875	45,561	0	0	15,817	55.00
56.00	05600	RADIOISOTOPE	3,583	4,686	0	0	9,313	56.00
60.00	06000	LABORATORY	0	0	0	0	83,337	60.00
65.00	06500	RESPIRATORY THERAPY	17,952	23,475	0	0	8,200	65.00
66.00	06600	PHYSICAL THERAPY	26,502	34,642	0	0	9,742	66.00
69.00	06900	ELECTROCARDIOLOGY	14,262	18,615	0	0	23,539	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	583,869	0	45,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	238,482	0	14,410	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	878,732	164,830	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	757	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,457	8,432	0	0	2,677	90.00
91.00	09100	EMERGENCY	77,164	100,857	0	0	87,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493,178	643,624	822,351	878,732	716,392	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	493,178	643,624	822,351	878,732	716,392	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,866,853	0	4,866,853		30.00
31.00	03100	INTENSIVE CARE UNIT	1,710,265	0	1,710,265		31.00
40.00	04000	SUBPROVIDER - IPF	2,595,126	0	2,595,126		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,462,364	0	3,462,364		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,272	0	4,501,272		54.00
54.01	05401	ULTRASOUND	210,983	0	210,983		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,295,636	0	1,295,636		55.00
56.00	05600	RADIOISOTOPE	259,682	0	259,682		56.00
60.00	06000	LABORATORY	3,302,606	0	3,302,606		60.00
65.00	06500	RESPIRATORY THERAPY	626,928	0	626,928		65.00
66.00	06600	PHYSICAL THERAPY	1,132,155	0	1,132,155		66.00
69.00	06900	ELECTROCARDIOLOGY	471,918	0	471,918		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,197,193	0	2,197,193		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	815,955	0	815,955		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,006,513	0	11,006,513		73.00
76.00	03020	ONCOLOGY	0	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	26,721	0	26,721		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	369,614	0	369,614		90.00
91.00	09100	EMERGENCY	4,102,229	0	4,102,229		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,954,013	0	42,954,013		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,034	0	40,034		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,267,550	0	3,267,550		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	193,215	0	193,215		194.00
194.01	07951	SPORTS MEDICINE	0	0	0		194.01
194.02	07952	COMMUNITY IND HEALTH	214,557	0	214,557		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	46,669,369	0	46,669,369		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	45,162	426	45,588	45,588	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	980,447	9,256	989,703	2,833	5.00
7.00	00700	OPERATION OF PLANT	0	496,220	4,684	500,904	770	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	193,266	1,824	195,090	592	8.00
9.00	00900	HOUSEKEEPING	0	15,429	146	15,575	0	9.00
10.00	01000	DIETARY	0	192,454	1,817	194,271	711	10.00
11.00	01100	CAFETERIA	0	105,565	997	106,562	740	11.00
13.00	01300	NURSING ADMINISTRATION	0	63,277	597	63,874	813	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	353,613	3,338	356,951	273	14.00
15.00	01500	PHARMACY	0	18,739	177	18,916	1,782	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	120,869	1,141	122,010	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	982,447	9,275	991,722	5,926	30.00
31.00	03100	INTENSIVE CARE UNIT	0	117,371	1,108	118,479	2,895	31.00
40.00	04000	SUBPROVIDER - IPF	0	269,223	2,542	271,765	4,153	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	391,841	3,699	395,540	5,848	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	966,829	9,127	975,956	4,467	54.00
54.01	05401	ULTRASOUND	0	17,553	166	17,719	391	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	1,982	55.00
56.00	05600	RADIOISOTOPE	0	16,678	157	16,835	335	56.00
60.00	06000	LABORATORY	0	336,435	3,176	339,611	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,361	239	25,600	1,247	65.00
66.00	06600	PHYSICAL THERAPY	0	145,480	1,373	146,853	2,080	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,176	190	20,366	959	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	88,200	833	89,033	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	266,787	2,519	269,306	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	53,157	502	53,659	578	90.00
91.00	09100	EMERGENCY	0	392,404	3,704	396,108	6,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,674,983	63,013	6,737,996	45,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,925	207	22,132	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	114	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	105,815	999	106,814	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	0	101,443	958	102,401	76	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,904,166	65,177	6,969,343	45,588	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	992,536					5.00
7.00	00700	OPERATION OF PLANT	53,296	554,970				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,224	19,928	225,834			8.00
9.00	00900	HOUSEKEEPING	13,659	1,591	25,037	55,862		9.00
10.00	01000	DIETARY	12,106	19,844	1,517	2,078	230,527	10.00
11.00	01100	CAFETERIA	9,134	10,885	0	1,140	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,862	6,524	0	683	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,703	36,461	833	3,818	0	14.00
15.00	01500	PHARMACY	17,666	1,932	0	202	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,685	12,463	0	1,305	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,635	101,298	68,486	10,607	114,308	30.00
31.00	03100	INTENSIVE CARE UNIT	31,460	12,102	6,423	1,267	21,203	31.00
40.00	04000	SUBPROVIDER - IPF	41,956	27,759	21,066	2,907	95,016	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,435	40,403	30,171	4,231	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,884	99,689	8,395	10,439	0	54.00
54.01	05401	ULTRASOUND	3,779	1,810	0	190	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	25,507	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	4,935	1,720	0	180	0	56.00
60.00	06000	LABORATORY	64,147	34,690	0	3,633	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,890	2,615	1,163	274	0	65.00
66.00	06600	PHYSICAL THERAPY	20,388	15,000	5,867	1,571	0	66.00
69.00	06900	ELECTROCARDIOLOGY	8,578	2,080	0	218	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,216	9,094	0	952	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,975	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,475	27,508	0	2,881	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	552	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,805	5,481	0	574	0	90.00
91.00	09100	EMERGENCY	73,511	40,461	56,876	4,237	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	916,463	531,338	225,834	53,387	230,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	570	2,261	0	237	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,491	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,751	10,911	0	1,143	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	3,261	10,460	0	1,095	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	992,536	554,970	225,834	55,862	230,527	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	128,461					11.00
13.00	01300	NURSING ADMINISTRATION	166	84,922				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,081	716	412,836			14.00
15.00	01500	PHARMACY	4,149	2,747	0	47,394		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	149,463	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,063	13,279	0	0	5,250	30.00
31.00	03100	INTENSIVE CARE UNIT	8,280	5,484	0	0	1,504	31.00
40.00	04000	SUBPROVIDER - IPF	11,912	7,884	0	0	3,565	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,665	13,018	0	0	8,295	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,878	9,846	0	0	31,248	54.00
54.01	05401	ULTRASOUND	1,174	776	0	0	2,567	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	9,084	6,012	0	0	3,299	55.00
56.00	05600	RADIOISOTOPE	933	618	0	0	1,942	56.00
60.00	06000	LABORATORY	0	0	0	0	17,382	60.00
65.00	06500	RESPIRATORY THERAPY	4,676	3,097	0	0	1,710	65.00
66.00	06600	PHYSICAL THERAPY	6,903	4,571	0	0	2,032	66.00
69.00	06900	ELECTROCARDIOLOGY	3,715	2,456	0	0	4,910	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	293,114	0	9,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	119,722	0	3,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,394	34,425	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	158	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,682	1,113	0	0	558	90.00
91.00	09100	EMERGENCY	20,100	13,305	0	0	18,172	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,461	84,922	412,836	47,394	149,463	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	128,461	84,922	412,836	47,394	149,463	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,406,574	0	1,406,574		30.00
31.00	03100	INTENSIVE CARE UNIT	209,097	0	209,097		31.00
40.00	04000	SUBPROVIDER - IPF	487,983	0	487,983		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	579,606	0	579,606		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,802	0	1,231,802		54.00
54.01	05401	ULTRASOUND	28,406	0	28,406		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	45,884	0	45,884		55.00
56.00	05600	RADIOISOTOPE	27,498	0	27,498		56.00
60.00	06000	LABORATORY	459,463	0	459,463		60.00
65.00	06500	RESPIRATORY THERAPY	52,272	0	52,272		65.00
66.00	06600	PHYSICAL THERAPY	205,265	0	205,265		66.00
69.00	06900	ELECTROCARDIOLOGY	43,282	0	43,282		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	433,850	0	433,850		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,702	0	134,702		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	589,989	0	589,989		73.00
76.00	03020	ONCOLOGY	0	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	710	0	710		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	70,450	0	70,450		90.00
91.00	09100	EMERGENCY	628,793	0	628,793		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,635,626	0	6,635,626		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,200	0	25,200		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,605	0	69,605		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	121,619	0	121,619		194.00
194.01	07951	SPORTS MEDICINE	0	0	0		194.01
194.02	07952	COMMUNITY IND HEALTH	117,293	0	117,293		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,969,343	0	6,969,343		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	110,529					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		110,529				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	723	723	10,971,669			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,696	15,696	681,902	-8,136,871	38,532,498	5.00
7.00	00700	OPERATION OF PLANT	7,944	7,944	185,214	0	2,069,120	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,094	3,094	142,494	0	396,915	8.00
9.00	00900	HOUSEKEEPING	247	247	0	0	530,264	9.00
10.00	01000	DIETARY	3,081	3,081	171,200	0	469,979	10.00
11.00	01100	CAFETERIA	1,690	1,690	178,139	0	354,603	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	1,013	195,718	0	499,357	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,661	5,661	65,743	0	493,171	14.00
15.00	01500	PHARMACY	300	300	428,874	0	685,848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,935	1,935	0	0	531,275	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,728	15,728	1,426,189	0	2,936,377	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	1,879	696,744	0	1,221,355	31.00
40.00	04000	SUBPROVIDER - IPF	4,310	4,310	999,496	0	1,628,853	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,273	6,273	1,407,460	0	2,423,912	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,478	15,478	1,075,194	0	2,984,841	54.00
54.01	05401	ULTRASOUND	281	281	94,161	0	146,714	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	476,945	0	990,269	55.00
56.00	05600	RADIOISOTOPE	267	267	80,660	0	191,582	56.00
60.00	06000	LABORATORY	5,386	5,386	0	0	2,490,384	60.00
65.00	06500	RESPIRATORY THERAPY	406	406	300,051	0	461,587	65.00
66.00	06600	PHYSICAL THERAPY	2,329	2,329	500,702	0	791,519	66.00
69.00	06900	ELECTROCARDIOLOGY	323	323	230,811	0	333,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412	1,412	0	0	1,250,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	464,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,271	4,271	0	0	8,092,991	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	21,437	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	851	851	139,071	0	264,186	90.00
91.00	09100	EMERGENCY	6,282	6,282	1,449,197	0	2,853,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,860	106,860	10,925,965	-8,136,871	35,579,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	351	0	0	22,132	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	27,439	0	2,697,848	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,694	1,694	0	0	106,814	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	1,624	1,624	18,265	0	126,614	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,904,166	65,177	3,572,905		8,136,871	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	62.464747	0.589682	0.325648		0.211169	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			45,588		992,536	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004155		0.025758	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	86,166					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,094	256,881				8.00
9.00	00900	HOUSEKEEPING	247	28,479	82,825			9.00
10.00	01000	DIETARY	3,081	1,726	3,081	21,712		10.00
11.00	01100	CAFETERIA	1,690	0	1,690	0	13,901	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	0	1,013	0	18	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,661	948	5,661	0	117	14.00
15.00	01500	PHARMACY	300	0	300	0	449	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,935	0	1,935	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,728	77,900	15,728	10,766	2,171	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	7,306	1,879	1,997	896	31.00
40.00	04000	SUBPROVIDER - IPF	4,310	23,962	4,310	8,949	1,289	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,273	34,319	6,273	0	2,128	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,478	9,549	15,478	0	1,610	54.00
54.01	05401	ULTRASOUND	281	0	281	0	127	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	983	55.00
56.00	05600	RADIOISOTOPE	267	0	267	0	101	56.00
60.00	06000	LABORATORY	5,386	0	5,386	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	406	1,323	406	0	506	65.00
66.00	06600	PHYSICAL THERAPY	2,329	6,674	2,329	0	747	66.00
69.00	06900	ELECTROCARDIOLOGY	323	0	323	0	402	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412	0	1,412	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	4,271	0	4,271	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	851	0	851	0	182	90.00
91.00	09100	EMERGENCY	6,282	64,695	6,282	0	2,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,497	256,881	79,156	21,712	13,901	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	0	351	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,694	0	1,694	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	COMMUNITY IND HEALTH	1,624	0	1,624	0	0	194.02
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)	2,506,054	570,717	712,695	689,178	493,178	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.084024	2.221717	8.604829	31.741802	35.477879	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	554,970	225,834	55,862	230,527	128,461	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.440707	0.879139	0.674458	10.617493	9.241134	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 3:17 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	28,876,338					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	243,350	100				14.00
15.00	01500	PHARMACY	933,982	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	184,908,143		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,515,147	0	0	6,497,251		30.00
31.00	03100	INTENSIVE CARE UNIT	1,864,697	0	0	1,861,463		31.00
40.00	04000	SUBPROVIDER - IPF	2,680,718	0	0	4,412,655		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,426,373	0	0	10,266,495		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,347,874	0	0	38,673,421		54.00
54.01	05401	ULTRASOUND	263,925	0	0	3,177,101		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,044,101	0	0	4,082,973		55.00
56.00	05600	RADIOISOTOPE	210,225	0	0	2,403,938		56.00
60.00	06000	LABORATORY	0	0	0	21,511,848		60.00
65.00	06500	RESPIRATORY THERAPY	1,053,205	0	0	2,116,661		65.00
66.00	06600	PHYSICAL THERAPY	1,554,225	0	0	2,514,806		66.00
69.00	06900	ELECTROCARDIOLOGY	835,180	0	0	6,076,224		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71	0	11,684,201		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29	0	3,719,634		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	42,532,631		73.00
76.00	03020	ONCOLOGY	0	0	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	195,392		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	378,325	0	0	690,907		90.00
91.00	09100	EMERGENCY	4,525,011	0	0	22,490,542		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,876,338	100	100	184,908,143		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0		194.01
194.02	07952	COMMUNITY IND HEALTH	0	0	0	0		194.02
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)	643,624	822,351	878,732	716,392		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.022289	8,223.510000	8,787.320000	0.003874		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	84,922	412,836	47,394	149,463		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002941	4,128.360000	473.940000	0.000808		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 3:17 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	4,866,853		4,866,853	0	4,866,853	30.00
31.00	03100	INTENSIVE CARE UNIT	1,710,265		1,710,265	0	1,710,265	31.00
40.00	04000	SUBPROVIDER - IPF	2,595,126		2,595,126	0	2,595,126	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,462,364		3,462,364	0	3,462,364	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,272		4,501,272	0	4,501,272	54.00
54.01	05401	ULTRASOUND	210,983		210,983	0	210,983	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,295,636		1,295,636	0	1,295,636	55.00
56.00	05600	RADIOISOTOPE	259,682		259,682	0	259,682	56.00
60.00	06000	LABORATORY	3,302,606		3,302,606	0	3,302,606	60.00
65.00	06500	RESPIRATORY THERAPY	626,928	0	626,928	0	626,928	65.00
66.00	06600	PHYSICAL THERAPY	1,132,155	0	1,132,155	0	1,132,155	66.00
69.00	06900	ELECTROCARDIOLOGY	471,918		471,918	0	471,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,197,193		2,197,193	0	2,197,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	815,955		815,955	0	815,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,006,513		11,006,513	0	11,006,513	73.00
76.00	03020	ONCOLOGY	0		0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	26,721		26,721	0	26,721	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	369,614		369,614	0	369,614	90.00
91.00	09100	EMERGENCY	4,102,229		4,102,229	0	4,102,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,412,136		1,412,136		1,412,136	92.00
200.00		Subtotal (see instructions)	44,366,149	0	44,366,149	0	44,366,149	200.00
201.00		Less Observation Beds	1,412,136		1,412,136		1,412,136	201.00
202.00		Total (see instructions)	42,954,013	0	42,954,013	0	42,954,013	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 3:17 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,723,808		3,723,808			30.00
31.00	03100	INTENSIVE CARE UNIT	1,861,463		1,861,463			31.00
40.00	04000	SUBPROVIDER - IPF	4,412,655		4,412,655			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,398,947	8,867,548	10,266,495	0.337249	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,930,308	34,743,113	38,673,421	0.116392	0.000000	54.00
54.01	05401	ULTRASOUND	281,930	2,895,171	3,177,101	0.066407	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	11,405	4,071,568	4,082,973	0.317327	0.000000	55.00
56.00	05600	RADIOISOTOPE	97,576	2,306,362	2,403,938	0.108024	0.000000	56.00
60.00	06000	LABORATORY	4,818,686	16,693,162	21,511,848	0.153525	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,355,136	761,525	2,116,661	0.296187	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	293,648	2,221,158	2,514,806	0.450196	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	939,156	5,137,068	6,076,224	0.077666	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,106,613	8,577,588	11,684,201	0.188048	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,797,731	1,921,903	3,719,634	0.219364	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,441,415	35,091,216	42,532,631	0.258778	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	0.000000	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	195,392	195,392	0.136756	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	690,907	690,907	0.534969	0.000000	90.00
91.00	09100	EMERGENCY	2,166,489	20,324,053	22,490,542	0.182398	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,773,443	2,773,443	0.509164	0.000000	92.00
200.00		Subtotal (see instructions)	37,636,966	147,271,177	184,908,143			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,636,966	147,271,177	184,908,143			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 3:17 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
40.00	04000	SUBPROVIDER - IPF		40.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.337249	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116392	54.00
54.01	05401	ULTRASOUND	0.066407	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317327	55.00
56.00	05600	RADIOISOTOPE	0.108024	56.00
60.00	06000	LABORATORY	0.153525	60.00
65.00	06500	RESPIRATORY THERAPY	0.296187	65.00
66.00	06600	PHYSICAL THERAPY	0.450196	66.00
69.00	06900	ELECTROCARDIOLOGY	0.077666	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188048	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258778	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136756	76.98
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.534969	90.00
91.00	09100	EMERGENCY	0.182398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.509164	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,866,853		4,866,853	0	4,866,853	30.00
31.00	03100	INTENSIVE CARE UNIT	1,710,265		1,710,265	0	1,710,265	31.00
40.00	04000	SUBPROVIDER - IPF	2,595,126		2,595,126	0	2,595,126	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,462,364		3,462,364	0	3,462,364	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,272		4,501,272	0	4,501,272	54.00
54.01	05401	ULTRASOUND	210,983		210,983	0	210,983	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,295,636		1,295,636	0	1,295,636	55.00
56.00	05600	RADIOISOTOPE	259,682		259,682	0	259,682	56.00
60.00	06000	LABORATORY	3,302,606		3,302,606	0	3,302,606	60.00
65.00	06500	RESPIRATORY THERAPY	626,928	0	626,928	0	626,928	65.00
66.00	06600	PHYSICAL THERAPY	1,132,155	0	1,132,155	0	1,132,155	66.00
69.00	06900	ELECTROCARDIOLOGY	471,918		471,918	0	471,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,197,193		2,197,193	0	2,197,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	815,955		815,955	0	815,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,006,513		11,006,513	0	11,006,513	73.00
76.00	03020	ONCOLOGY	0		0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	26,721		26,721	0	26,721	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	369,614		369,614	0	369,614	90.00
91.00	09100	EMERGENCY	4,102,229		4,102,229	0	4,102,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,412,136		1,412,136		1,412,136	92.00
200.00		Subtotal (see instructions)	44,366,149	0	44,366,149	0	44,366,149	200.00
201.00		Less Observation Beds	1,412,136		1,412,136		1,412,136	201.00
202.00		Total (see instructions)	42,954,013	0	42,954,013	0	42,954,013	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,723,808		3,723,808			30.00
31.00	03100	INTENSIVE CARE UNIT	1,861,463		1,861,463			31.00
40.00	04000	SUBPROVIDER - IPF	4,412,655		4,412,655			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,398,947	8,867,548	10,266,495	0.337249	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,930,308	34,743,113	38,673,421	0.116392	0.000000	54.00
54.01	05401	ULTRASOUND	281,930	2,895,171	3,177,101	0.066407	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	11,405	4,071,568	4,082,973	0.317327	0.000000	55.00
56.00	05600	RADIOISOTOPE	97,576	2,306,362	2,403,938	0.108024	0.000000	56.00
60.00	06000	LABORATORY	4,818,686	16,693,162	21,511,848	0.153525	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,355,136	761,525	2,116,661	0.296187	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	293,648	2,221,158	2,514,806	0.450196	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	939,156	5,137,068	6,076,224	0.077666	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,106,613	8,577,588	11,684,201	0.188048	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,797,731	1,921,903	3,719,634	0.219364	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,441,415	35,091,216	42,532,631	0.258778	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	0.000000	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	195,392	195,392	0.136756	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	690,907	690,907	0.534969	0.000000	90.00
91.00	09100	EMERGENCY	2,166,489	20,324,053	22,490,542	0.182398	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,773,443	2,773,443	0.509164	0.000000	92.00
200.00		Subtotal (see instructions)	37,636,966	147,271,177	184,908,143			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,636,966	147,271,177	184,908,143			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/31/2018 3:17 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	1,406,574	0	1,406,574	3,798	370.35	30.00
31.00	INTENSIVE CARE UNIT	209,097		209,097	500	418.19	31.00
40.00	SUBPROVIDER - IPF	487,983	0	487,983	2,241	217.75	40.00
200.00	Total (lines 30 through 199)	2,103,654		2,103,654	6,539		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	1,640	607,374				30.00
31.00	INTENSIVE CARE UNIT	251	104,966				31.00
40.00	SUBPROVIDER - IPF	1,961	427,008				40.00
200.00	Total (lines 30 through 199)	3,852	1,139,348				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 3:17 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	579,606	10,266,495	0.056456	598,488	33,788	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,802	38,673,421	0.031851	2,187,085	69,661	54.00
54.01	05401	ULTRASOUND	28,406	3,177,101	0.008941	157,058	1,404	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	45,884	4,082,973	0.011238	4,666	52	55.00
56.00	05600	RADIOISOTOPE	27,498	2,403,938	0.011439	62,983	720	56.00
60.00	06000	LABORATORY	459,463	21,511,848	0.021359	2,683,367	57,314	60.00
65.00	06500	RESPIRATORY THERAPY	52,272	2,116,661	0.024695	709,897	17,531	65.00
66.00	06600	PHYSICAL THERAPY	205,265	2,514,806	0.081623	160,176	13,074	66.00
69.00	06900	ELECTROCARDIOLOGY	43,282	6,076,224	0.007123	554,818	3,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	433,850	11,684,201	0.037131	1,372,626	50,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,702	3,719,634	0.036214	682,469	24,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	589,989	42,532,631	0.013871	3,881,751	53,844	73.00
76.00	03020	ONCOLOGY	0	0	0.000000	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	710	195,392	0.003634	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	70,450	690,907	0.101967	0	0	90.00
91.00	09100	EMERGENCY	628,793	22,490,542	0.027958	1,169,110	32,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	408,123	2,773,443	0.147154	0	0	92.00
200.00		Total (lines 50 through 199)	4,940,095	174,910,217		14,224,494	359,708	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,798	0.00	1,640	30.00
31.00	03100	INTENSIVE CARE UNIT		0	500	0.00	251	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,241	0.00	1,961	40.00
200.00		Total (lines 30 through 199)		0	6,539		3,852	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,266,495	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,673,421	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,177,101	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,082,973	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,403,938	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	21,511,848	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,116,661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,514,806	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,076,224	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,684,201	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,719,634	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	42,532,631	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	195,392	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	690,907	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,490,542	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,773,443	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	174,910,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	598,488	0	3,016,546	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,187,085	0	10,707,075	0	54.00
54.01	05401	ULTRASOUND	0.000000	157,058	0	801,508	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	4,666	0	1,291,187	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	62,983	0	1,089,106	0	56.00
60.00	06000	LABORATORY	0.000000	2,683,367	0	3,424,940	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	709,897	0	276,226	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	160,176	0	23,600	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	554,818	0	1,970,623	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,372,626	0	1,955,942	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	682,469	0	743,566	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,881,751	0	11,478,608	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	161,312	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	278,944	0	90.00
91.00	09100	EMERGENCY	0.000000	1,169,110	0	5,022,625	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	948,917	0	92.00
200.00		Total (lines 50 through 199)		14,224,494	0	43,190,725	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 3:17 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	0.337249	3,016,546	0	0	1,017,327	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116392	10,707,075	0	0	1,246,218	54.00
54.01	05401	ULTRASOUND	0.066407	801,508	0	0	53,226	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317327	1,291,187	0	0	409,728	55.00
56.00	05600	RADIOISOTOPE	0.108024	1,089,106	0	0	117,650	56.00
60.00	06000	LABORATORY	0.153525	3,424,940	0	0	525,814	60.00
65.00	06500	RESPIRATORY THERAPY	0.296187	276,226	0	0	81,815	65.00
66.00	06600	PHYSICAL THERAPY	0.450196	23,600	0	0	10,625	66.00
69.00	06900	ELECTROCARDIOLOGY	0.077666	1,970,623	0	0	153,050	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188048	1,955,942	0	0	367,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219364	743,566	0	0	163,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258778	11,478,608	0	7,805	2,970,411	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136756	161,312	0	0	22,060	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.534969	278,944	0	0	149,226	90.00
91.00	09100	EMERGENCY	0.182398	5,022,625	0	0	916,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.509164	948,917	0	0	483,154	92.00
200.00		Subtotal (see instructions)		43,190,725	0	7,805	8,687,344	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		43,190,725	0	7,805	8,687,344	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | 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	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	2,020		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	2,020		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,020		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | 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	579,606	10,266,495	0.056456	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,802	38,673,421	0.031851	104,666	3,334	54.00
54.01	05401	ULTRASOUND	28,406	3,177,101	0.008941	5,253	47	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	45,884	4,082,973	0.011238	0	0	55.00
56.00	05600	RADIOISOTOPE	27,498	2,403,938	0.011439	0	0	56.00
60.00	06000	LABORATORY	459,463	21,511,848	0.021359	337,843	7,216	60.00
65.00	06500	RESPIRATORY THERAPY	52,272	2,116,661	0.024695	37,789	933	65.00
66.00	06600	PHYSICAL THERAPY	205,265	2,514,806	0.081623	33,668	2,748	66.00
69.00	06900	ELECTROCARDIOLOGY	43,282	6,076,224	0.007123	38,701	276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	433,850	11,684,201	0.037131	148,344	5,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,702	3,719,634	0.036214	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	589,989	42,532,631	0.013871	586,865	8,140	73.00
76.00	03020	ONCOLOGY	0	0	0.000000	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	710	195,392	0.003634	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	70,450	690,907	0.101967	0	0	90.00
91.00	09100	EMERGENCY	628,793	22,490,542	0.027958	122,883	3,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,773,443	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,531,972	174,910,217		1,416,012	31,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,266,495	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,673,421	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,177,101	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,082,973	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,403,938	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	21,511,848	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,116,661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,514,806	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,076,224	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,684,201	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,719,634	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	42,532,631	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	195,392	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	690,907	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,490,542	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,773,443	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	174,910,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	104,666	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	5,253	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	337,843	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	37,789	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	33,668	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	38,701	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	148,344	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	586,865	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	122,883	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,416,012	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 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)	3,798	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,798	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,696	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)	1,640	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)	4,866,853	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)	4,866,853	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)	4,866,853	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)	1,281.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,101,545	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)	2,101,545	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,710,265	500	3,420.53	251	858,553	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,838,124	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,798,222	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)	712,340	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	359,708	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,072,048	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,726,174	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)	1,102	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,281.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,412,136	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 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	1,406,574	4,866,853	0.289011	1,412,136	408,123	90.00
91.00	Nursing School cost	0	4,866,853	0.000000	1,412,136	0	91.00
92.00	Allied health cost	0	4,866,853	0.000000	1,412,136	0	92.00
93.00	All other Medical Education	0	4,866,853	0.000000	1,412,136	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/31/2018 3:17 am
	Title XVIII	Subprovider - IPF	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)	2,241	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,241	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,241	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)	1,961	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)	2,595,126	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)	2,595,126	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,595,126	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)	1,158.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,270,877	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)	2,270,877	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	295,932	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,566,809	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)	427,008	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	31,638	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	458,646	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,108,163	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 15-S022 | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | 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	487,983	2,595,126	0.188038	0	0	90.00
91.00	Nursing School cost	0	2,595,126	0.000000	0	0	91.00
92.00	Allied health cost	0	2,595,126	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,595,126	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,798	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,798	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,696	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)	34	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)	4,866,853	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)	4,866,853	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)	4,866,853	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)	1,281.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	43,569	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)	43,569	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,710,265	500	3,420.53	48	164,185	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	55,004	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	262,758	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,102	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,281.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,412,136	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,406,574	4,866,853	0.289011	1,412,136	408,123	90.00
91.00	Nursing School cost	0	4,866,853	0.000000	1,412,136	0	91.00
92.00	Allied health cost	0	4,866,853	0.000000	1,412,136	0	92.00
93.00	All other Medical Education	0	4,866,853	0.000000	1,412,136	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/31/2018 3:17 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,241	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,241	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,241	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)	0	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)	2,595,126	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)	2,595,126	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,595,126	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)	1,158.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/31/2018 3:17 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	487,983	2,595,126	0.188038	0	0	90.00
91.00	Nursing School cost	0	2,595,126	0.000000	0	0	91.00
92.00	Allied health cost	0	2,595,126	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,595,126	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 3:17 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		2,356,925		30.00
31.00	03100	INTENSIVE CARE UNIT		999,151		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.337249	598,488	201,839	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116392	2,187,085	254,559	54.00
54.01	05401	ULTRASOUND	0.066407	157,058	10,430	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317327	4,666	1,481	55.00
56.00	05600	RADIOISOTOPE	0.108024	62,983	6,804	56.00
60.00	06000	LABORATORY	0.153525	2,683,367	411,964	60.00
65.00	06500	RESPIRATORY THERAPY	0.296187	709,897	210,262	65.00
66.00	06600	PHYSICAL THERAPY	0.450196	160,176	72,111	66.00
69.00	06900	ELECTROCARDIOLOGY	0.077666	554,818	43,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188048	1,372,626	258,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219364	682,469	149,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258778	3,881,751	1,004,512	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136756	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.534969	0	0	90.00
91.00	09100	EMERGENCY	0.182398	1,169,110	213,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.509164	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,224,494	2,838,124	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)		14,224,494		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,852,874		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.337249	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116392	104,666	12,182	54.00
54.01	05401	ULTRASOUND	0.066407	5,253	349	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317327	0	0	55.00
56.00	05600	RADIOISOTOPE	0.108024	0	0	56.00
60.00	06000	LABORATORY	0.153525	337,843	51,867	60.00
65.00	06500	RESPIRATORY THERAPY	0.296187	37,789	11,193	65.00
66.00	06600	PHYSICAL THERAPY	0.450196	33,668	15,157	66.00
69.00	06900	ELECTROCARDIOLOGY	0.077666	38,701	3,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188048	148,344	27,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219364	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258778	586,865	151,868	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136756	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.534969	0	0	90.00
91.00	09100	EMERGENCY	0.182398	122,883	22,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.509164	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,416,012	295,932	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,416,012		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 3:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		37,084		30.00
31.00	03100	INTENSIVE CARE UNIT		34,581		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.337249	19,013	6,412	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116392	50,849	5,918	54.00
54.01	05401	ULTRASOUND	0.066407	1,484	99	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317327	0	0	55.00
56.00	05600	RADIOISOTOPE	0.108024	0	0	56.00
60.00	06000	LABORATORY	0.153525	47,519	7,295	60.00
65.00	06500	RESPIRATORY THERAPY	0.296187	19,034	5,638	65.00
66.00	06600	PHYSICAL THERAPY	0.450196	725	326	66.00
69.00	06900	ELECTROCARDIOLOGY	0.077666	10,636	826	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188048	37,738	7,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219364	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258778	66,657	17,249	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136756	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.534969	0	0	90.00
91.00	09100	EMERGENCY	0.182398	22,717	4,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.509164	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		276,372	55,004	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)		276,372		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 3:17 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)	3,138,539	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,199,934	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)	18,243	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	1,520,308	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	25.98	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 § 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 § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	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 § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	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)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/31/2018 3:17 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)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,356,716		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	4,210,279		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	4,356,716	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	357,601	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)	4,714,317	59.00
60.00	Primary payer payments	5,772	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,708,545	61.00
62.00	Deductibles billed to program beneficiaries	559,188	62.00
63.00	Coinsurance billed to program beneficiaries	6,909	63.00
64.00	Allowable bad debts (see instructions)	89,179	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	57,966	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,986	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,200,414	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		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)	21,577	70.93
70.94	HRR adjustment amount (see instructions)	-72,149	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 3:17 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)	2017	474,466	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)	2018	184,821	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,809,129	71.00
71.01	Sequestration adjustment (see instructions)		96,183	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		4,660,647	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		52,299	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0055317790	1.0035125329	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)	0.9803	0.9914	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,138,539	0	3,138,539		3,138,539	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,199,934	0		1,199,934	1,199,934	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	18,243	0	14,453	3,790	18,243	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,520,308	0	1,155,246	365,062	1,520,308	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,356,716	0	3,152,992	1,203,724	4,356,716	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,356,716	0	3,152,992	1,203,724	4,356,716	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	357,601	0	257,804	99,797	357,601	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,410,796	1,303,521	4,714,317	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	351,841	0	254,128	97,713	351,841	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,760	0	3,676	2,084	5,760	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	357,601	0	257,804	99,797	357,601	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.139107	0.141786		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			474,466		474,466	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				184,821	184,821	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/31/2018 3:17 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,020	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,687,344	2.00
3.00	OPPS payments	7,138,138	3.00
4.00	Outlier payment (see instructions)	18,800	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,020	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,805	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)	7,805	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)	7,805	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,785	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	2,020	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	7,156,938	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,380,414	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)	5,778,544	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)	5,778,544	30.00
31.00	Primary payer payments	322	31.00
32.00	Subtotal (line 30 minus line 31)	5,778,222	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)	194,116	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	126,175	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	118,911	36.00
37.00	Subtotal (see instructions)	5,904,397	37.00
38.00	MSP-LCC reconciliation amount from PS&R	2	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,904,395	40.00
40.01	Sequestration adjustment (see instructions)	118,088	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,794,861	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-8,554	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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2018 3:17 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		4,633,047		5,763,261	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/02/2017	27,600	08/02/2017	31,600	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)		27,600		31,600	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)		4,660,647		5,794,861	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		52,299		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		8,554	6.02
7.00	Total Medicare program liability (see instructions)		4,712,946		5,786,307	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0022 | Component CCN: 15-S022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2018 3:17 am

Title XVIII | Subprovider - IPF | 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		1,843,781		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,843,781		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,843,781		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/31/2018 3:17 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		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/31/2018 3:17 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,929,596	1.00
2.00	Net IPF PPS Outlier Payments	90,238	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	6.139726	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,019,834	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,019,834	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,019,834	18.00
19.00	Deductibles	126,252	19.00
20.00	Subtotal (line 18 minus line 19)	1,893,582	20.00
21.00	Coinsurance	12,173	21.00
22.00	Subtotal (line 20 minus line 21)	1,881,409	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,881,409	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,881,409	31.00
31.01	Sequestration adjustment (see instructions)	37,628	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,843,781	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	90,238	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2018 3:17 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	262,758		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	262,758	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	262,758	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	276,372	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	276,372	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	276,372	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	13,614	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	262,758	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	262,758	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	262,758	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	262,758	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	262,758	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)	262,758	0	40.00
41.00	Interim payments	262,758	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2018 3:17 am
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/31/2018 3:17 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	3,243	0	0	0	1.00
2.00	Temporary investments	933,763	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,348,143	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,667,471	0	0	0	6.00
7.00	Inventory	1,323,292	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	304,374	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)	9,245,344	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	970,120	0	0	0	12.00
13.00	Land improvements	3,795,629	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	39,813,866	0	0	0	15.00
16.00	Accumulated depreciation	-32,521,353	0	0	0	16.00
17.00	Leasehold improvements	507,273	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,570,443	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,135,978	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,381,322	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,182,096	0	0	0	37.00
38.00	Salaries, wages, and fees payable	919,862	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	299,436	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,401,394	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-2,931,542	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-2,931,542	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	469,852	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	41,911,470				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)	41,911,470	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,381,322	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/31/2018 3:17 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		39,048,143		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,950,660				2.00
3.00	Total (sum of line 1 and line 2)		48,998,803		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)		48,998,803		0		11.00
12.00	ADJUST TO AFS	7,087,333		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)		7,087,333		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		41,911,470		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	ADJUST TO AFS		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: 15-0022 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2018 3:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,723,808		3,723,808	1.00
2.00	SUBPROVIDER - IPF	4,412,655		4,412,655	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,136,463		8,136,463	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,861,463		1,861,463	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,861,463		1,861,463	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,997,926		9,997,926	17.00
18.00	Ancillary services	25,472,551	123,482,774	148,955,325	18.00
19.00	Outpatient services	2,166,489	23,788,403	25,954,892	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN	0	3,548,066	3,548,066	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	37,636,966	150,819,243	188,456,209	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		49,334,871		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)		49,334,871		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/31/2018 3:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	188,456,209	1.00
2.00	Less contractual allowances and discounts on patients' accounts	129,919,847	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,536,362	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	49,334,871	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,201,491	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	12,470	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	194,093	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	15,778	13.00
14.00	Revenue from meals sold to employees and guests	93,222	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	1,172	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	5,810	21.00
22.00	Rental of hospital space	241,690	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	184,934	24.00
25.00	Total other income (sum of lines 6-24)	749,169	25.00
26.00	Total (line 5 plus line 25)	9,950,660	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)	9,950,660	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0022	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/31/2018 3:17 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	351,841	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,760	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)	8.76	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	357,601	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