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: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/31/2018 1:55 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2018 Time: 1:55 pm
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 MUNSTER (15-0165) 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	56,678	113,294	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	56,678	113,294	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 12:22 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 701 SUPERIOR STREET	PO Box:			1.00
2.00	City: MUNSTER	State: IN	Zip Code: 46321	County: LAKE	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 MUNSTER	150165	23844	1	06/01/2007	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	762	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 12:22 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.				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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 12:22 pm

		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	

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 12:22 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	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.					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

		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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	221,690	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 12:22 pm

	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,	Contractor's Name: WISCONSIN PHYSICIAN SERVICE	Contractor's Number: 8001	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box:		142.00
143.00	City: MISHAWAKA	State:	Zip Code: 46546	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	11/30/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2018 12:22 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/18/2018	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/06/2018	Y	04/06/2018	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2018 12:22 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	MATTHEW	DEETS	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ST. MARGARET HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-932-2300 X33148	MATTHEW.DEETS@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 12:22 pm

		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.	SR. ANALYST		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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2018 12:22 pm

	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	54	19,710	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)		54	19,710	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	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)		63	22,995	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		63				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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2018 12:22 pm

	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)	4,662	681	9,139			1.00
2.00	HMO and other (see instructions)	1,771	0				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)	4,662	681	9,139			7.00
8.00	INTENSIVE CARE UNIT	547	81	1,666			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)	5,209	762	10,805	0.00	369.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	369.66	27.00
28.00	Observation Bed Days		79	2,961			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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2018 12:22 pm

	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	1,113	194	2,419	1.00
2.00	HMO and other (see instructions)			337	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,113	194	2,419	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 12:22 pm

		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	24,477,532	0	24,477,532	768,885.00	31.84	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)		491,029	0	491,029	2,923.00	167.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		686,052	0	686,052	10,435.84	65.74	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		161,246	0	161,246	1,187.00	135.84	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		4,397,881	0	4,397,881	141,176.00	31.15	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)		6,445,188	0	6,445,188			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		72,514	0	72,514			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)		1,914,639	0	1,914,639			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	520,291	0	520,291	11,248.00	46.26	26.00
27.00	Administrative & General	5.00	2,173,719	0	2,173,719	73,751.00	29.47	27.00

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 12:22 pm

		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.)		201,279	0	201,279	2,686.00	74.94	28.00
29.00	Maintenance & Repairs	6.00	541,010	0	541,010	18,200.00	29.73	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	513,644	0	513,644	40,001.00	12.84	32.00
33.00	Housekeeping under contract (see instructions)		4,499	0	4,499	345.81	13.01	33.00
34.00	Dietary	10.00	481,783	0	481,783	32,307.00	14.91	34.00
35.00	Dietary under contract (see instructions)		2,494	0	2,494	166.00	15.02	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	977,993	0	977,993	23,649.00	41.35	38.00
39.00	Central Services and Supply	14.00	220,915	0	220,915	11,816.00	18.70	39.00
40.00	Pharmacy	15.00	935,710	0	935,710	20,531.00	45.58	40.00
41.00	Medical Records & Medical Records Library	16.00	264,655	0	264,655	6,213.00	42.60	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2018 12:22 pm

		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)		24,685,804	0	24,685,804	772,082.81	31.97	1.00
2.00	Excluded area salaries (see instructions)		491,029	0	491,029	2,923.00	167.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,194,775	0	24,194,775	769,159.81	31.46	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,245,179	0	5,245,179	152,798.84	34.33	4.00
5.00	Subtotal wage-related costs (see inst.)		8,359,827	0	8,359,827	0.00	34.55	5.00
6.00	Total (sum of lines 3 thru 5)		37,799,781	0	37,799,781	921,958.65	41.00	6.00
7.00	Total overhead cost (see instructions)		6,837,992	0	6,837,992	240,913.81	28.38	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2018 12:22 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	677,304	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)	604,000	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)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,024,911	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,408	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)	266,067	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	270,210	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,654,722	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,080	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)	6,517,702	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2018 12:22 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/31/2018 12:22 pm

		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)	0.237570	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,107,595	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?	N	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	33,162,665	6.00
7.00	Medicaid cost (line 1 times line 6)	7,878,454	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)	2,770,859	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)	2,770,859	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)	2,401,214	3,601,932	6,003,146	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	570,456	3,601,932	4,172,388	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)	570,456	3,601,932	4,172,388	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)	2,397,182	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	167,949	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	258,382	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,138,800	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	598,548	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,770,936	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,541,795	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 12:22 pm

		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		6,313,969	6,313,969	-582,933	5,731,036	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	520,291	6,561,348	7,081,639	-13,899	7,067,740	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,173,719	10,093,757	12,267,476	-58,520	12,208,956	5.00
6.00	00600	MAINTENANCE & REPAIRS	541,010	2,187,607	2,728,617	0	2,728,617	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,859	71,859	0	71,859	8.00
9.00	00900	HOUSEKEEPING	513,644	177,404	691,048	0	691,048	9.00
10.00	01000	DIETARY	481,783	298,724	780,507	-16	780,491	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	977,993	176,707	1,154,700	-65,656	1,089,044	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	220,915	569,537	790,452	-1,134	789,318	14.00
15.00	01500	PHARMACY	935,710	3,080,075	4,015,785	-2,495,787	1,519,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,655	677,826	942,481	0	942,481	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,747,895	1,306,441	6,054,336	-47,423	6,006,913	30.00
31.00	03100	INTENSIVE CARE UNIT	1,080,380	121,529	1,201,909	-33,443	1,168,466	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,023,065	9,450,837	12,473,902	-7,211,015	5,262,887	50.00
51.00	05100	RECOVERY ROOM	1,112,390	216,939	1,329,329	-93,408	1,235,921	51.00
53.00	05300	ANESTHESIOLOGY	31,467	606,659	638,126	-71,823	566,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,012,273	936,115	2,948,388	-262,823	2,685,565	54.00
57.00	05700	CT SCAN	483,800	633,719	1,117,519	-7,689	1,109,830	57.00
58.00	05800	MRI	266,790	735,015	1,001,805	-1,213	1,000,592	58.00
59.00	05900	CARDIAC CATHETERIZATION	943,423	1,538,443	2,481,866	-1,461,625	1,020,241	59.00
60.00	06000	LABORATORY	0	3,534,857	3,534,857	-1,562	3,533,295	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	605,333	112,204	717,537	-14,941	702,596	65.00
66.00	06600	PHYSICAL THERAPY	256,073	14,787	270,860	-124	270,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,284	839	52,123	-637	51,486	67.00
68.00	06800	SPEECH PATHOLOGY	33,160	315	33,475	0	33,475	68.00
69.00	06900	ELECTROCARDIOLOGY	269,817	28,512	298,329	-2,834	295,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	416,594	870,909	1,287,503	-2,333	1,285,170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,501,400	2,501,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,571,476	6,571,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,781,299	2,781,299	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	4,721	0	4,721	0	4,721	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	184,316	13,638	197,954	0	197,954	76.01
76.02	03952	WOUND CARE	77,331	20,513	97,844	-10,345	87,499	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	99	99	0	99	90.01
90.02	09002	CLINIC	394,238	314,115	708,353	-26,697	681,656	90.02
91.00	09100	EMERGENCY	1,362,433	519,973	1,882,406	-29,959	1,852,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-643,664	-643,664	643,664	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,986,503	50,541,607	74,528,110	0	74,528,110	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,197	-9,936	-2,739	0	-2,739	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	474,510	39,732	514,242	0	514,242	192.00
192.01	19201	CENTER OF HOPE	9,322	450	9,772	0	9,772	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	24,477,532	50,571,853	75,049,385	0	75,049,385	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 12:22 pm

		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	2,729,218	8,460,254	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	42,000	7,109,740	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-771,484	11,437,472	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,728,617	6.00
7.00	00700	OPERATION OF PLANT	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,859	8.00
9.00	00900	HOUSEKEEPING	0	691,048	9.00
10.00	01000	DIETARY	0	780,491	10.00
11.00	01100	CAFETERIA	-198,284	-198,284	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,089,044	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-369,594	419,724	14.00
15.00	01500	PHARMACY	52,754	1,572,752	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-102,276	840,205	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-1,008,066	4,998,847	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,168,466	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-573,053	4,689,834	50.00
51.00	05100	RECOVERY ROOM	0	1,235,921	51.00
53.00	05300	ANESTHESIOLOGY	0	566,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,732	2,677,833	54.00
57.00	05700	CT SCAN	-5,688	1,104,142	57.00
58.00	05800	MRI	-17,939	982,653	58.00
59.00	05900	CARDIAC CATHETERIZATION	-44,070	976,171	59.00
60.00	06000	LABORATORY	-5,270	3,528,025	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	702,596	65.00
66.00	06600	PHYSICAL THERAPY	0	270,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	51,486	67.00
68.00	06800	SPEECH PATHOLOGY	0	33,475	68.00
69.00	06900	ELECTROCARDIOLOGY	0	295,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-6,314	1,278,856	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,501,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,571,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,781,299	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	4,721	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	-2,725	195,229	76.01
76.02	03952	WOUND CARE	0	87,499	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	99	90.01
90.02	09002	CLINIC	-8,775	672,881	90.02
91.00	09100	EMERGENCY	0	1,852,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-297,298	74,230,812	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	-2,739	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	514,242	192.00
192.01	19201	CENTER OF HOPE	0	9,772	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-297,298	74,752,087	200.00

RECLASSIFICATIONS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 12:22 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	60,731	1.00
2.00		0.00	0	0	2.00
	0		0	60,731	
	B - INTEREST EXPENSE				
1.00	INTEREST EXPENSE	113.00	0	643,664	1.00
	0		0	643,664	
	C - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,781,299	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
	0		0	2,781,299	
	D - MED SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,501,400	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	2,501,400	
	E - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,571,476	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
	0		0	6,571,476	
500.00	Grand Total: Increases		0	12,558,570	500.00

RECLASSIFICATIONS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 12:22 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - INSURANCE					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,211	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	58,520	0	2.00
	0		0	60,731		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	643,664	11	1.00
	0		0	643,664		
	C - DRUG EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,696	0	1.00
2.00	DIETARY	10.00	0	16	0	2.00
3.00	PHARMACY	15.00	0	2,495,787	0	3.00
4.00	OPERATING ROOM	50.00	0	3,713	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	13,664	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	243,562	0	6.00
7.00	CT SCAN	57.00	0	7	0	7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	283	0	8.00
9.00	LABORATORY	60.00	0	695	0	9.00
10.00	WOUND CARE	76.02	0	6,092	0	10.00
11.00	CLINIC	90.02	0	6,464	0	11.00
12.00	EMERGENCY	91.00	0	320	0	12.00
	0		0	2,781,299		
	D - MED SUPPLIES EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,203	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	26,754	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,134	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	47,423	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	19,614	0	5.00
6.00	OPERATING ROOM	50.00	0	1,701,918	0	6.00
7.00	RECOVERY ROOM	51.00	0	93,408	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	58,159	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,261	0	9.00
10.00	CT SCAN	57.00	0	7,682	0	10.00
11.00	MRI	58.00	0	1,213	0	11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	449,178	0	12.00
13.00	LABORATORY	60.00	0	867	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	14,941	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	124	0	15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	637	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	2,834	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	122	0	18.00
19.00	WOUND CARE	76.02	0	4,253	0	19.00
20.00	CLINIC	90.02	0	19,036	0	20.00
21.00	EMERGENCY	91.00	0	29,639	0	21.00
	0		0	2,501,400		
	E - IMPLANTABLE DEVICES					
1.00	NURSING ADMINISTRATION	13.00	0	38,902	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	13,829	0	2.00
3.00	OPERATING ROOM	50.00	0	5,505,384	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	1,012,164	0	4.00
5.00	CLINIC	90.02	0	1,197	0	5.00
	0		0	6,571,476		
500.00	Grand Total: Decreases		0	12,558,570		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2018 12:22 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,869,989	71,238	0	71,238	0	1.00
2.00	Land Improvements	2,638,876	14,937	0	14,937	0	2.00
3.00	Buildings and Fixtures	49,751,780	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	64,795,714	11,625,208	0	11,625,208	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	125,056,359	11,711,383	0	11,711,383	0	8.00
9.00	Reconciling Items	-10,032,477	-25,494,887	0	-25,494,887	0	9.00
10.00	Total (line 8 minus line 9)	135,088,836	37,206,270	0	37,206,270	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,941,227	0	1.00
2.00	Land Improvements	2,653,813	0	2.00
3.00	Buildings and Fixtures	49,751,780	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	76,420,922	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	136,767,742	0	8.00
9.00	Reconciling Items	-35,527,364	0	9.00
10.00	Total (line 8 minus line 9)	172,295,106	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2018 12:22 pm

	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	6,313,969	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,313,969	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6,313,969	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	6,313,969	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2018 12:22 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,708,165	0	4,708,165	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	4,708,165	0	4,708,165	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,587,742	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,587,742	0	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	872,512	0	0	0	8,460,254	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	872,512	0	0	0	8,460,254	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 12:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-5,541	CAP REL COSTS-BLDG & FIXT	1.00	9	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	-413,457	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	-1,647,538			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	3,479,123			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-191,052	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,460	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	-7,232	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROPERTY TAXES (51009800)	A	-4,441	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 12:22 pm

	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	ADVERTISING (41860XXX)	A	-1,561	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RENTAL INCOME	B	-275,704	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS - OTHER OPERATING	B	-614	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DISCOUNTS/REBATES	B	-735	CARDIAC CATHETERIZATION	59.00	0	33.04
33.05	HAF ASSESSMENT FEES	A	-1,202,446	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENSION	A	42,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	MEDICAL STAFF FEES	B	-34,000	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	INTEREST INCOME - OTHER	B	-490	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-5,702	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	LOBBYING	A	-771	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PROPERTY TAXES (51009800)	A	-2,030	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	PROPERTY TAXES (51009800)	A	-5,688	CT SCAN	57.00	0	33.12
33.13	PROPERTY TAXES (51009800)	A	-17,939	MRI	58.00	0	33.13
33.14	MISC OTHER OPERATING	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-297,298				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: 15-0165

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

Worksheet A-8-1

Date/Time Prepared: 5/31/2018 12:22 pm

	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	1,516,176	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	1,218,583	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	8,626,203	7,462,723	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	0	369,594	4.00
4.01	15.00	PHARMACY	FA-COEP	123,275	70,521	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HIM	574,055	676,331	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,058,292	8,579,169	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	FRANCISCAN ALLI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 Date/Time Prepared: 5/31/2018 12:22 pm

	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	1,516,176	11	1.00
2.00	1,218,583	9	2.00
3.00	1,163,480	0	3.00
4.00	-369,594	0	4.00
4.01	52,754	0	4.01
4.02	-102,276	0	4.02
5.00	3,479,123		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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2018 12:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	252,616	252,616	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	755,450	755,450	0	0	0	2.00
3.00	50.00	OPERATING ROOM	559,229	559,229	0	0	0	3.00
4.00	50.00	OPERATING ROOM	3,750	0	3,750	200,300	30	4.00
5.00	50.00	OPERATING ROOM	36,075	75	36,000	200,300	240	5.00
6.00	59.00	CARDIAC CATHETERIZATION	20,003	11,790	8,213	200,300	66	6.00
7.00	59.00	CARDIAC CATHETERIZATION	29,688	29,688	0	200,300	0	7.00
8.00	60.00	LABORATORY	18,270	0	18,270	200,300	135	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	27,500	0	27,500	200,300	220	9.00
10.00	76.01	CARDIAC AND PULMONARY REHAB	2,725	2,725	0	0	0	10.00
11.00	90.02	CLINIC	8,775	8,775	0	0	0	11.00
200.00			1,714,081	1,620,348	93,733		691	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,889	144	0	0	0	4.00
5.00	50.00	OPERATING ROOM	23,112	1,156	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	6,356	318	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	13,000	650	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	21,186	1,059	0	0	0	9.00
10.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	10.00
11.00	90.02	CLINIC	0	0	0	0	0	11.00
200.00			66,543	3,327	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	252,616		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	755,450		2.00
3.00	50.00	OPERATING ROOM	0	0	0	559,229		3.00
4.00	50.00	OPERATING ROOM	0	2,889	861	861		4.00
5.00	50.00	OPERATING ROOM	0	23,112	12,888	12,963		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	6,356	1,857	13,647		6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	29,688		7.00
8.00	60.00	LABORATORY	0	13,000	5,270	5,270		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	21,186	6,314	6,314		9.00
10.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	2,725		10.00
11.00	90.02	CLINIC	0	0	0	8,775		11.00
200.00			0	66,543	27,190	1,647,538		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,460,254	8,460,254				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,109,740	107,958	0	7,217,698		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,437,472	1,044,416	0	654,885	13,136,773	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,728,617	0	0	162,992	2,891,609	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,859	0	0	0	71,859	8.00
9.00	00900	HOUSEKEEPING	691,048	0	0	154,748	845,796	9.00
10.00	01000	DIETARY	780,491	372,860	0	145,149	1,298,500	10.00
11.00	01100	CAFETERIA	-198,284	0	0	0	-198,284	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,089,044	0	0	294,644	1,383,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	419,724	0	0	66,556	486,280	14.00
15.00	01500	PHARMACY	1,572,752	144,828	0	281,905	1,999,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	840,205	6,815	0	79,734	926,754	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,998,847	1,816,830	0	1,430,420	8,246,097	30.00
31.00	03100	INTENSIVE CARE UNIT	1,168,466	437,796	0	325,490	1,931,752	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,689,834	824,571	0	910,771	6,425,176	50.00
51.00	05100	RECOVERY ROOM	1,235,921	361,738	0	335,134	1,932,793	51.00
53.00	05300	ANESTHESIOLOGY	566,303	0	0	9,480	575,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,677,833	383,367	0	606,246	3,667,446	54.00
57.00	05700	CT SCAN	1,104,142	0	0	145,756	1,249,898	57.00
58.00	05800	MRI	982,653	0	0	80,377	1,063,030	58.00
59.00	05900	CARDIAC CATHETERIZATION	976,171	778,804	0	284,229	2,039,204	59.00
60.00	06000	LABORATORY	3,528,025	133,847	0	0	3,661,872	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	702,596	66,687	0	182,371	951,654	65.00
66.00	06600	PHYSICAL THERAPY	270,736	0	0	77,148	347,884	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,486	0	0	15,451	66,937	67.00
68.00	06800	SPEECH PATHOLOGY	33,475	0	0	9,990	43,465	68.00
69.00	06900	ELECTROCARDIOLOGY	295,495	0	0	81,289	376,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,278,856	340,345	0	125,509	1,744,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,501,400	0	0	0	2,501,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,571,476	0	0	0	6,571,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,781,299	0	0	0	2,781,299	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	4,721	0	0	1,422	6,143	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	195,229	0	0	55,530	250,759	76.01
76.02	03952	WOUND CARE	87,499	0	0	23,298	110,797	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	99	0	0	0	99	90.01
90.02	09002	CLINIC	672,881	57,126	0	118,774	848,781	90.02
91.00	09100	EMERGENCY	1,852,447	468,560	0	410,466	2,731,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,230,812	7,346,548	0	7,069,764	72,969,172	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	-2,739	0	0	2,168	-571	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	514,242	1,113,706	0	142,958	1,770,906	192.00
192.01	19201	CENTER OF HOPE	9,772	0	0	2,808	12,580	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,752,087	8,460,254	0	7,217,698	74,752,087	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,136,773					5.00
6.00	00600	MAINTENANCE & REPAIRS	614,525	3,506,134				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,271	0	0	87,130		8.00
9.00	00900	HOUSEKEEPING	179,749	0	0	232	1,025,777	9.00
10.00	01000	DIETARY	275,957	178,889	0	0	52,337	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	294,061	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,344	0	0	0	0	14.00
15.00	01500	PHARMACY	424,931	69,485	0	0	20,329	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196,954	3,270	0	0	957	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,752,485	871,668	0	37,080	255,018	30.00
31.00	03100	INTENSIVE CARE UNIT	410,536	210,043	0	0	61,452	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,365,478	395,608	0	49,818	115,742	50.00
51.00	05100	RECOVERY ROOM	410,757	173,553	0	0	50,776	51.00
53.00	05300	ANESTHESIOLOGY	122,365	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	779,406	183,930	0	0	53,812	54.00
57.00	05700	CT SCAN	265,628	0	0	0	0	57.00
58.00	05800	MRI	225,915	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	433,372	373,650	0	0	109,317	59.00
60.00	06000	LABORATORY	778,221	64,216	0	0	18,788	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	202,246	31,995	0	0	9,361	65.00
66.00	06600	PHYSICAL THERAPY	73,932	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,225	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,237	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	80,074	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	370,786	163,289	0	0	47,773	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	531,598	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,396,570	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	591,082	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	1,306	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	53,291	0	0	0	0	76.01
76.02	03952	WOUND CARE	23,547	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	21	0	0	0	0	90.01
90.02	09002	CLINIC	180,383	27,408	0	0	8,019	90.02
91.00	09100	EMERGENCY	580,493	224,803	0	0	65,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,757,746	2,971,807	0	87,130	869,451	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	376,353	534,327	0	0	156,326	192.00
192.01	19201	CENTER OF HOPE	2,674	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,136,773	3,506,134	0	87,130	1,025,777	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,805,683					10.00
11.00	01100	CAFETERIA	0	-198,284				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,677,749		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	589,624	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	69	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,378,264	0	0	720,550	0	30.00
31.00	03100	INTENSIVE CARE UNIT	427,419	0	0	180,524	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	294,400	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	165,545	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	936	0	54.00
57.00	05700	CT SCAN	0	0	0	77	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	76,928	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	589,624	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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	54,108	0	90.02
91.00	09100	EMERGENCY	0	0	0	184,586	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,805,683	0	0	1,677,749	589,624	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
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	-198,284	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,805,683	-198,284	0	1,677,749	589,624	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,514,230					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,128,004				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	83,573	13,344,735	0	13,344,735	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,513	3,240,239	0	3,240,239	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	171,538	8,817,760	0	8,817,760	50.00
51.00	05100	RECOVERY ROOM	0	22,147	2,755,571	0	2,755,571	51.00
53.00	05300	ANESTHESIOLOGY	0	47,750	745,898	0	745,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,639	4,786,169	0	4,786,169	54.00
57.00	05700	CT SCAN	0	100,319	1,615,922	0	1,615,922	57.00
58.00	05800	MRI	0	66,244	1,355,189	0	1,355,189	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	63,159	3,095,630	0	3,095,630	59.00
60.00	06000	LABORATORY	0	81,684	4,604,781	0	4,604,781	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	17,151	1,212,407	0	1,212,407	65.00
66.00	06600	PHYSICAL THERAPY	0	5,960	427,776	0	427,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,334	82,496	0	82,496	67.00
68.00	06800	SPEECH PATHOLOGY	0	586	53,288	0	53,288	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,029	489,913	0	489,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	20,541	2,347,099	0	2,347,099	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	53,317	3,675,939	0	3,675,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,703	8,025,749	0	8,025,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,514,230	81,343	5,967,954	0	5,967,954	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	7,449	0	7,449	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	1,293	305,343	0	305,343	76.01
76.02	03952	WOUND CARE	0	1,495	135,839	0	135,839	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	120	0	120	90.01
90.02	09002	CLINIC	0	27,533	1,146,232	0	1,146,232	90.02
91.00	09100	EMERGENCY	0	71,153	3,858,278	0	3,858,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,514,230	1,128,004	72,097,776	0	72,097,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	-571	0	-571	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,837,912	0	2,837,912	192.00
192.01	19201	CENTER OF HOPE	0	0	15,254	0	15,254	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	-198,284	0	-198,284	201.00
202.00		TOTAL (sum lines 118 through 201)	2,514,230	1,128,004	74,752,087	0	74,752,087	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	107,958	0	107,958	107,958	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,044,416	0	1,044,416	9,795	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	2,438	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	2,314	9.00
10.00	01000	DIETARY	0	372,860	0	372,860	2,171	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	4,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	995	14.00
15.00	01500	PHARMACY	0	144,828	0	144,828	4,216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,815	0	6,815	1,193	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,816,830	0	1,816,830	21,403	30.00
31.00	03100	INTENSIVE CARE UNIT	0	437,796	0	437,796	4,868	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	824,571	0	824,571	13,622	50.00
51.00	05100	RECOVERY ROOM	0	361,738	0	361,738	5,012	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	383,367	0	383,367	9,067	54.00
57.00	05700	CT SCAN	0	0	0	0	2,180	57.00
58.00	05800	MRI	0	0	0	0	1,202	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	778,804	0	778,804	4,251	59.00
60.00	06000	LABORATORY	0	133,847	0	133,847	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	66,687	0	66,687	2,728	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	231	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	149	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,216	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	340,345	0	340,345	1,877	70.00
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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	21	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	831	76.01
76.02	03952	WOUND CARE	0	0	0	0	348	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	57,126	0	57,126	1,776	90.02
91.00	09100	EMERGENCY	0	468,560	0	468,560	6,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,346,548	0	7,346,548	105,746	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	32	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,113,706	0	1,113,706	2,138	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	42	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,460,254	0	8,460,254	107,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,054,211					5.00
6.00	00600	MAINTENANCE & REPAIRS	49,316	51,754				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,226	0	0	1,226		8.00
9.00	00900	HOUSEKEEPING	14,425	0	0	3	16,742	9.00
10.00	01000	DIETARY	22,146	2,641	0	0	854	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	23,599	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,294	0	0	0	0	14.00
15.00	01500	PHARMACY	34,101	1,026	0	0	332	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,806	48	0	0	16	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140,606	12,867	0	522	4,162	30.00
31.00	03100	INTENSIVE CARE UNIT	32,946	3,100	0	0	1,003	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109,581	5,840	0	701	1,889	50.00
51.00	05100	RECOVERY ROOM	32,964	2,562	0	0	829	51.00
53.00	05300	ANESTHESIOLOGY	9,820	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,548	2,715	0	0	878	54.00
57.00	05700	CT SCAN	21,317	0	0	0	0	57.00
58.00	05800	MRI	18,130	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,779	5,515	0	0	1,784	59.00
60.00	06000	LABORATORY	62,453	948	0	0	307	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	16,230	472	0	0	153	65.00
66.00	06600	PHYSICAL THERAPY	5,933	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,142	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	741	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,426	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,756	2,410	0	0	780	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,661	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	112,077	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,435	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	105	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	4,277	0	0	0	0	76.01
76.02	03952	WOUND CARE	1,890	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	2	0	0	0	0	90.01
90.02	09002	CLINIC	14,476	405	0	0	131	90.02
91.00	09100	EMERGENCY	46,585	3,318	0	0	1,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,023,793	43,867	0	1,226	14,191	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	30,203	7,887	0	0	2,551	192.00
192.01	19201	CENTER OF HOPE	215	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,054,211	51,754	0	1,226	16,742	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	400,672					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	28,006		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	9,289	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	305,830	0	0	12,030	0	30.00
31.00	03100	INTENSIVE CARE UNIT	94,842	0	0	3,013	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,914	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,763	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16	0	54.00
57.00	05700	CT SCAN	0	0	0	1	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,284	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	9,289	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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	903	0	90.02
91.00	09100	EMERGENCY	0	0	0	3,081	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	400,672	0	0	28,006	9,289	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
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	400,672	0	0	28,006	9,289	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	184,503					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,879				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,776	2,316,026	0	2,316,026	30.00
31.00	03100	INTENSIVE CARE UNIT	0	393	577,961	0	577,961	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,552	964,670	0	964,670	50.00
51.00	05100	RECOVERY ROOM	0	471	406,339	0	406,339	51.00
53.00	05300	ANESTHESIOLOGY	0	1,015	10,977	0	10,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,139	460,730	0	460,730	54.00
57.00	05700	CT SCAN	0	2,132	25,630	0	25,630	57.00
58.00	05800	MRI	0	1,408	20,740	0	20,740	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,342	827,759	0	827,759	59.00
60.00	06000	LABORATORY	0	1,736	199,291	0	199,291	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	365	86,635	0	86,635	65.00
66.00	06600	PHYSICAL THERAPY	0	127	7,214	0	7,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28	1,401	0	1,401	67.00
68.00	06800	SPEECH PATHOLOGY	0	12	902	0	902	68.00
69.00	06900	ELECTROCARDIOLOGY	0	702	8,344	0	8,344	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	437	375,605	0	375,605	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,133	53,083	0	53,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,226	113,303	0	113,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,503	1,729	233,667	0	233,667	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	126	0	126	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	27	5,135	0	5,135	76.01
76.02	03952	WOUND CARE	0	32	2,270	0	2,270	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	2	0	2	90.01
90.02	09002	CLINIC	0	585	75,402	0	75,402	90.02
91.00	09100	EMERGENCY	0	1,512	530,268	0	530,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,503	23,879	7,303,480	0	7,303,480	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	32	0	32	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,156,485	0	1,156,485	192.00
192.01	19201	CENTER OF HOPE	0	0	257	0	257	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	184,503	23,879	8,460,254	0	8,460,254	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 12:22 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	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	178,753					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		178,753				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,281	2,281	23,957,241			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,067	22,067	2,173,719	-13,136,773	61,814,169	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	541,010	0	2,891,609	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	71,859	8.00
9.00	00900	HOUSEKEEPING	0	0	513,644	0	845,796	9.00
10.00	01000	DIETARY	7,878	7,878	481,783	0	1,298,500	10.00
11.00	01100	CAFETERIA	0	0	0	198,284	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	977,993	0	1,383,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	220,915	0	486,280	14.00
15.00	01500	PHARMACY	3,060	3,060	935,710	0	1,999,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144	144	264,655	0	926,754	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,387	38,387	4,747,895	0	8,246,097	30.00
31.00	03100	INTENSIVE CARE UNIT	9,250	9,250	1,080,380	0	1,931,752	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,422	17,422	3,023,065	0	6,425,176	50.00
51.00	05100	RECOVERY ROOM	7,643	7,643	1,112,390	0	1,932,793	51.00
53.00	05300	ANESTHESIOLOGY	0	0	31,467	0	575,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,100	8,100	2,012,273	0	3,667,446	54.00
57.00	05700	CT SCAN	0	0	483,800	0	1,249,898	57.00
58.00	05800	MRI	0	0	266,790	0	1,063,030	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,455	16,455	943,423	0	2,039,204	59.00
60.00	06000	LABORATORY	2,828	2,828	0	0	3,661,872	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	605,333	0	951,654	65.00
66.00	06600	PHYSICAL THERAPY	0	0	256,073	0	347,884	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	51,284	0	66,937	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	33,160	0	43,465	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	269,817	0	376,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,191	7,191	416,594	0	1,744,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,501,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,571,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,781,299	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	4,721	0	6,143	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	184,316	0	250,759	76.01
76.02	03952	WOUND CARE	0	0	77,331	0	110,797	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	99	90.01
90.02	09002	CLINIC	1,207	1,207	394,238	0	848,781	90.02
91.00	09100	EMERGENCY	9,900	9,900	1,362,433	0	2,731,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,222	155,222	23,466,212	-12,938,489	60,030,683	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	7,197	571	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,531	23,531	474,510	0	1,770,906	192.00
192.01	19201	CENTER OF HOPE	0	0	9,322	0	12,580	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,460,254	0	7,217,698		13,136,773	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.329298	0.000000	0.301274		0.212520	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			107,958		1,054,211	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004506		0.017055	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

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		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	154,405					6.00
7.00	00700	OPERATION OF PLANT	0	154,405				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	318,394			8.00
9.00	00900	HOUSEKEEPING	0	0	848	154,405		9.00
10.00	01000	DIETARY	7,878	7,878	0	7,878	65,169	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,060	3,060	0	3,060	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144	144	0	144	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	38,387	38,387	135,500	38,387	49,743	30.00
31.00	03100	INTENSIVE CARE UNIT	9,250	9,250	0	9,250	15,426	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,422	17,422	182,046	17,422	0	50.00
51.00	05100	RECOVERY ROOM	7,643	7,643	0	7,643	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,100	8,100	0	8,100	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,455	16,455	0	16,455	0	59.00
60.00	06000	LABORATORY	2,828	2,828	0	2,828	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	0	1,409	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,191	7,191	0	7,191	0	70.00
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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,207	1,207	0	1,207	0	90.02
91.00	09100	EMERGENCY	9,900	9,900	0	9,900	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,874	130,874	318,394	130,874	65,169	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	23,531	23,531	0	23,531	0	192.00
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,506,134	0	87,130	1,025,777	1,805,683	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.707386	0.000000	0.273655	6.643418	27.707698	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,754	0	1,226	16,742	400,672	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.335183	0.000000	0.003851	0.108429	6.148199	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

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		Cost Center Description	CAFETERIA (NUMBER HOUSED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	195,346			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	100		14.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	8	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	83,896	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	21,019	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	34,278	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	19,275	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	109	0	0	54.00
57.00	05700	CT SCAN	0	0	9	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	8,957	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	100	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	100	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	6,300	0	0	90.02
91.00	09100	EMERGENCY	0	0	21,492	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	195,346	100	100	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
192.01	19201	CENTER OF HOPE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	-198,284	0	1,677,749	589,624	2,514,230	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	8.588602	5,896.240000	25,142.300000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	28,006	9,289	184,503	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.143366	92.890000	1,845.030000	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

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		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			16.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
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	303,480,416	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	22,483,948	30.00
31.00	03100	INTENSIVE CARE UNIT	4,980,507	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	46,158,617	50.00
51.00	05100	RECOVERY ROOM	5,958,290	51.00
53.00	05300	ANESTHESIOLOGY	12,846,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,075,413	54.00
57.00	05700	CT SCAN	26,989,151	57.00
58.00	05800	MRI	17,822,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,991,972	59.00
60.00	06000	LABORATORY	21,975,832	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	64.01
65.00	06500	RESPIRATORY THERAPY	4,614,151	65.00
66.00	06600	PHYSICAL THERAPY	1,603,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	358,895	67.00
68.00	06800	SPEECH PATHOLOGY	157,540	68.00
69.00	06900	ELECTROCARDIOLOGY	8,886,057	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,526,203	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,344,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,524,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,884,166	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	347,906	76.01
76.02	03952	WOUND CARE	402,083	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
90.01	09001	CLINIC	0	90.01
90.02	09002	CLINIC	7,407,364	90.02
91.00	09100	EMERGENCY	19,142,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	303,480,416	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	CENTER OF HOPE	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,128,004	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003717	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,879	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000079	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 12:22 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,344,735		13,344,735	0	13,344,735	30.00
31.00	03100	INTENSIVE CARE UNIT	3,240,239		3,240,239	0	3,240,239	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,817,760		8,817,760	13,749	8,831,509	50.00
51.00	05100	RECOVERY ROOM	2,755,571		2,755,571	0	2,755,571	51.00
53.00	05300	ANESTHESIOLOGY	745,898		745,898	0	745,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,786,169		4,786,169	0	4,786,169	54.00
57.00	05700	CT SCAN	1,615,922		1,615,922	0	1,615,922	57.00
58.00	05800	MRI	1,355,189		1,355,189	0	1,355,189	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,095,630		3,095,630	1,857	3,097,487	59.00
60.00	06000	LABORATORY	4,604,781		4,604,781	5,270	4,610,051	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0		0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,212,407	0	1,212,407	0	1,212,407	65.00
66.00	06600	PHYSICAL THERAPY	427,776	0	427,776	0	427,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,496	0	82,496	0	82,496	67.00
68.00	06800	SPEECH PATHOLOGY	53,288	0	53,288	0	53,288	68.00
69.00	06900	ELECTROCARDIOLOGY	489,913		489,913	0	489,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,347,099		2,347,099	6,314	2,353,413	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,675,939		3,675,939	0	3,675,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,025,749		8,025,749	0	8,025,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,967,954		5,967,954	0	5,967,954	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	7,449		7,449	0	7,449	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	305,343		305,343	0	305,343	76.01
76.02	03952	WOUND CARE	135,839		135,839	0	135,839	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	120		120	0	120	90.01
90.02	09002	CLINIC	1,146,232		1,146,232	0	1,146,232	90.02
91.00	09100	EMERGENCY	3,858,278		3,858,278	0	3,858,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,265,598		3,265,598		3,265,598	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,363,374	0	75,363,374	27,190	75,390,564	200.00
201.00		Less Observation Beds	3,265,598		3,265,598		3,265,598	201.00
202.00		Total (see instructions)	72,097,776	0	72,097,776	27,190	72,124,966	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 12:22 pm

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,826,813		17,826,813			30.00
31.00	03100	INTENSIVE CARE UNIT	4,980,507		4,980,507			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,609,111	37,549,506	46,158,617	0.191032	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,102,011	4,856,279	5,958,290	0.462477	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,678,507	10,167,749	12,846,256	0.058063	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,846,862	24,228,551	27,075,413	0.176772	0.000000	54.00
57.00	05700	CT SCAN	4,319,039	22,670,112	26,989,151	0.059873	0.000000	57.00
58.00	05800	MRI	1,597,318	16,224,690	17,822,008	0.076040	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,466,646	9,525,326	16,991,972	0.182182	0.000000	59.00
60.00	06000	LABORATORY	8,716,581	13,259,251	21,975,832	0.209538	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	4,067,410	546,741	4,614,151	0.262758	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,441,963	161,409	1,603,372	0.266798	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	335,008	23,887	358,895	0.229861	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	142,514	15,026	157,540	0.338251	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,298,366	6,587,691	8,886,057	0.055133	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,138,840	4,387,363	5,526,203	0.424722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,004,171	9,340,009	14,344,180	0.256267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,648,560	6,875,470	15,524,030	0.516989	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,307,541	8,576,625	21,884,166	0.272706	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	173,953	173,953	347,906	0.877659	0.000000	76.01
76.02	03952	WOUND CARE	9,915	392,168	402,083	0.337838	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	7,407,364	7,407,364	0.154742	0.000000	90.02
91.00	09100	EMERGENCY	4,503,190	14,639,285	19,142,475	0.201556	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,031,967	2,625,168	4,657,135	0.701203	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	103,246,793	200,233,623	303,480,416			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	103,246,793	200,233,623	303,480,416			202.00

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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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.191330	50.00
51.00	05100	RECOVERY ROOM	0.462477	51.00
53.00	05300	ANESTHESIOLOGY	0.058063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176772	54.00
57.00	05700	CT SCAN	0.059873	57.00
58.00	05800	MRI	0.076040	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182291	59.00
60.00	06000	LABORATORY	0.209778	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0.262758	65.00
66.00	06600	PHYSICAL THERAPY	0.266798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229861	67.00
68.00	06800	SPEECH PATHOLOGY	0.338251	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.425864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.256267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.516989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272706	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.877659	76.01
76.02	03952	WOUND CARE	0.337838	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.000000	90.01
90.02	09002	CLINIC	0.154742	90.02
91.00	09100	EMERGENCY	0.201556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.701203	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/31/2018 12:22 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,344,735		13,344,735	0	13,344,735	30.00
31.00	03100	INTENSIVE CARE UNIT	3,240,239		3,240,239	0	3,240,239	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,817,760		8,817,760	13,749	8,831,509	50.00
51.00	05100	RECOVERY ROOM	2,755,571		2,755,571	0	2,755,571	51.00
53.00	05300	ANESTHESIOLOGY	745,898		745,898	0	745,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,786,169		4,786,169	0	4,786,169	54.00
57.00	05700	CT SCAN	1,615,922		1,615,922	0	1,615,922	57.00
58.00	05800	MRI	1,355,189		1,355,189	0	1,355,189	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,095,630		3,095,630	1,857	3,097,487	59.00
60.00	06000	LABORATORY	4,604,781		4,604,781	5,270	4,610,051	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0		0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,212,407	0	1,212,407	0	1,212,407	65.00
66.00	06600	PHYSICAL THERAPY	427,776	0	427,776	0	427,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,496	0	82,496	0	82,496	67.00
68.00	06800	SPEECH PATHOLOGY	53,288	0	53,288	0	53,288	68.00
69.00	06900	ELECTROCARDIOLOGY	489,913		489,913	0	489,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,347,099		2,347,099	6,314	2,353,413	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,675,939		3,675,939	0	3,675,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,025,749		8,025,749	0	8,025,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,967,954		5,967,954	0	5,967,954	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	7,449		7,449	0	7,449	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	305,343		305,343	0	305,343	76.01
76.02	03952	WOUND CARE	135,839		135,839	0	135,839	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	120		120	0	120	90.01
90.02	09002	CLINIC	1,146,232		1,146,232	0	1,146,232	90.02
91.00	09100	EMERGENCY	3,858,278		3,858,278	0	3,858,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,265,598		3,265,598		3,265,598	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,363,374	0	75,363,374	27,190	75,390,564	200.00
201.00		Less Observation Beds	3,265,598		3,265,598		3,265,598	201.00
202.00		Total (see instructions)	72,097,776	0	72,097,776	27,190	72,124,966	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 12:22 pm

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,826,813		17,826,813			30.00
31.00	03100	INTENSIVE CARE UNIT	4,980,507		4,980,507			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,609,111	37,549,506	46,158,617	0.191032	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,102,011	4,856,279	5,958,290	0.462477	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,678,507	10,167,749	12,846,256	0.058063	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,846,862	24,228,551	27,075,413	0.176772	0.000000	54.00
57.00	05700	CT SCAN	4,319,039	22,670,112	26,989,151	0.059873	0.000000	57.00
58.00	05800	MRI	1,597,318	16,224,690	17,822,008	0.076040	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,466,646	9,525,326	16,991,972	0.182182	0.000000	59.00
60.00	06000	LABORATORY	8,716,581	13,259,251	21,975,832	0.209538	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	4,067,410	546,741	4,614,151	0.262758	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,441,963	161,409	1,603,372	0.266798	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	335,008	23,887	358,895	0.229861	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	142,514	15,026	157,540	0.338251	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,298,366	6,587,691	8,886,057	0.055133	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,138,840	4,387,363	5,526,203	0.424722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,004,171	9,340,009	14,344,180	0.256267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,648,560	6,875,470	15,524,030	0.516989	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,307,541	8,576,625	21,884,166	0.272706	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	173,953	173,953	347,906	0.877659	0.000000	76.01
76.02	03952	WOUND CARE	9,915	392,168	402,083	0.337838	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	7,407,364	7,407,364	0.154742	0.000000	90.02
91.00	09100	EMERGENCY	4,503,190	14,639,285	19,142,475	0.201556	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,031,967	2,625,168	4,657,135	0.701203	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	103,246,793	200,233,623	303,480,416			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	103,246,793	200,233,623	303,480,416			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.191330	50.00
51.00	05100	RECOVERY ROOM	0.462477	51.00
53.00	05300	ANESTHESIOLOGY	0.058063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176772	54.00
57.00	05700	CT SCAN	0.059873	57.00
58.00	05800	MRI	0.076040	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182291	59.00
60.00	06000	LABORATORY	0.209778	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0.262758	65.00
66.00	06600	PHYSICAL THERAPY	0.266798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229861	67.00
68.00	06800	SPEECH PATHOLOGY	0.338251	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.425864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.256267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.516989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272706	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.877659	76.01
76.02	03952	WOUND CARE	0.337838	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.000000	90.01
90.02	09002	CLINIC	0.154742	90.02
91.00	09100	EMERGENCY	0.201556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.701203	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,817,760	964,670	7,853,090	0	0	50.00
51.00	05100	RECOVERY ROOM	2,755,571	406,339	2,349,232	0	0	51.00
53.00	05300	ANESTHESIOLOGY	745,898	10,977	734,921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,786,169	460,730	4,325,439	0	0	54.00
57.00	05700	CT SCAN	1,615,922	25,630	1,590,292	0	0	57.00
58.00	05800	MRI	1,355,189	20,740	1,334,449	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,095,630	827,759	2,267,871	0	0	59.00
60.00	06000	LABORATORY	4,604,781	199,291	4,405,490	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,212,407	86,635	1,125,772	0	0	65.00
66.00	06600	PHYSICAL THERAPY	427,776	7,214	420,562	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,496	1,401	81,095	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	53,288	902	52,386	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	489,913	8,344	481,569	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,347,099	375,605	1,971,494	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,675,939	53,083	3,622,856	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,025,749	113,303	7,912,446	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,967,954	233,667	5,734,287	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	7,449	126	7,323	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	305,343	5,135	300,208	0	0	76.01
76.02	03952	WOUND CARE	135,839	2,270	133,569	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	120	2	118	0	0	90.01
90.02	09002	CLINIC	1,146,232	75,402	1,070,830	0	0	90.02
91.00	09100	EMERGENCY	3,858,278	530,268	3,328,010	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,265,598	566,758	2,698,840	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	58,778,400	4,976,251	53,802,149	0	0	200.00
201.00		Less Observation Beds	3,265,598	566,758	2,698,840	0	0	201.00
202.00		Total (line 200 minus line 201)	55,512,802	4,409,493	51,103,309	0	0	202.00

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

Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,817,760	46,158,617	0.191032	50.00
51.00	05100	RECOVERY ROOM	2,755,571	5,958,290	0.462477	51.00
53.00	05300	ANESTHESIOLOGY	745,898	12,846,256	0.058063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,786,169	27,075,413	0.176772	54.00
57.00	05700	CT SCAN	1,615,922	26,989,151	0.059873	57.00
58.00	05800	MRI	1,355,189	17,822,008	0.076040	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,095,630	16,991,972	0.182182	59.00
60.00	06000	LABORATORY	4,604,781	21,975,832	0.209538	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	1,212,407	4,614,151	0.262758	65.00
66.00	06600	PHYSICAL THERAPY	427,776	1,603,372	0.266798	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,496	358,895	0.229861	67.00
68.00	06800	SPEECH PATHOLOGY	53,288	157,540	0.338251	68.00
69.00	06900	ELECTROCARDIOLOGY	489,913	8,886,057	0.055133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,347,099	5,526,203	0.424722	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,675,939	14,344,180	0.256267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,025,749	15,524,030	0.516989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,967,954	21,884,166	0.272706	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	7,449	0	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	305,343	347,906	0.877659	76.01
76.02	03952	WOUND CARE	135,839	402,083	0.337838	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	09001	CLINIC	120	0	0.000000	90.01
90.02	09002	CLINIC	1,146,232	7,407,364	0.154742	90.02
91.00	09100	EMERGENCY	3,858,278	19,142,475	0.201556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,265,598	4,657,135	0.701203	92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	58,778,400	280,673,096		200.00
201.00		Less Observation Beds	3,265,598	0		201.00
202.00		Total (line 200 minus line 201)	55,512,802	280,673,096		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/31/2018 12:22 pm

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	2,316,026	0	2,316,026	12,100	191.41	30.00
31.00	INTENSIVE CARE UNIT	577,961		577,961	1,666	346.92	31.00
200.00	Total (lines 30 through 199)	2,893,987		2,893,987	13,766		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	4,662	892,353	30.00
31.00	INTENSIVE CARE UNIT	547	189,765	31.00
200.00	Total (lines 30 through 199)	5,209	1,082,118	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 12:22 pm

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	964,670	46,158,617	0.020899	5,021,481	104,944	50.00
51.00	05100	RECOVERY ROOM	406,339	5,958,290	0.068197	460,508	31,405	51.00
53.00	05300	ANESTHESIOLOGY	10,977	12,846,256	0.000854	853,323	729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,730	27,075,413	0.017017	271,584	4,622	54.00
57.00	05700	CT SCAN	25,630	26,989,151	0.000950	2,044,578	1,942	57.00
58.00	05800	MRI	20,740	17,822,008	0.001164	675,128	786	58.00
59.00	05900	CARDIAC CATHETERIZATION	827,759	16,991,972	0.048715	375,258	18,281	59.00
60.00	06000	LABORATORY	199,291	21,975,832	0.009069	4,687,853	42,514	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	86,635	4,614,151	0.018776	2,091,144	39,263	65.00
66.00	06600	PHYSICAL THERAPY	7,214	1,603,372	0.004499	731,474	3,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,401	358,895	0.003904	173,225	676	67.00
68.00	06800	SPEECH PATHOLOGY	902	157,540	0.005726	83,431	478	68.00
69.00	06900	ELECTROCARDIOLOGY	8,344	8,886,057	0.000939	272,663	256	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	375,605	5,526,203	0.067968	327,026	22,227	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,083	14,344,180	0.003701	1,462,765	5,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,303	15,524,030	0.007299	3,694,801	26,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,667	21,884,166	0.010677	6,776,820	72,356	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	126	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	5,135	347,906	0.014760	44,257	653	76.01
76.02	03952	WOUND CARE	2,270	402,083	0.005646	2,798	16	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	2	0	0.000000	0	0	90.01
90.02	09002	CLINIC	75,402	7,407,364	0.010179	0	0	90.02
91.00	09100	EMERGENCY	530,268	19,142,475	0.027701	1,464,753	40,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,758	4,657,135	0.121697	636,890	77,508	92.00
200.00		Total (lines 50 through 199)	4,976,251	280,673,096		32,151,760	494,904	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/31/2018 12:22 pm

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
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	12,100	0.00	4,662	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,666	0.00	547	31.00
200.00		Total (lines 30 through 199)		0	13,766		5,209	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
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 12:22 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 12:22 pm

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	46,158,617	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,958,290	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,846,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,075,413	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	26,989,151	0.000000	57.00
58.00	05800	MRI	0	0	0	17,822,008	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,991,972	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	21,975,832	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,614,151	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,603,372	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	358,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	157,540	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,886,057	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,526,203	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,344,180	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,524,030	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,884,166	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	347,906	0.000000	76.01
76.02	03952	WOUND CARE	0	0	0	402,083	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	7,407,364	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,142,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,657,135	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	280,673,096		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 12:22 pm

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		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	5,021,481	0	8,920,449	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	460,508	0	1,402,390	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	853,323	0	2,130,138	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	271,584	0	4,217,418	0	54.00
57.00	05700	CT SCAN	0.000000	2,044,578	0	5,914,570	0	57.00
58.00	05800	MRI	0.000000	675,128	0	3,178,390	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	375,258	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,687,853	0	2,318,783	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.000000	2,091,144	0	160,025	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	731,474	0	32,218	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	173,225	0	5,863	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	83,431	0	3,018	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	272,663	0	4,077,230	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	327,026	0	1,259,862	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,462,765	0	1,457,307	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,694,801	0	1,887,030	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,776,820	0	2,613,583	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.000000	44,257	0	0	0	76.01
76.02	03952	WOUND CARE	0.000000	2,798	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	69,942	0	90.02
91.00	09100	EMERGENCY	0.000000	1,464,753	0	2,276,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	636,890	0	822,820	0	92.00
200.00		Total (lines 50 through 199)		32,151,760	0	42,747,702	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 12:22 pm

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	0.191032	8,920,449	0	0	1,704,091	50.00
51.00	05100	RECOVERY ROOM	0.462477	1,402,390	0	0	648,573	51.00
53.00	05300	ANESTHESIOLOGY	0.058063	2,130,138	0	0	123,682	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176772	4,217,418	0	0	745,521	54.00
57.00	05700	CT SCAN	0.059873	5,914,570	0	0	354,123	57.00
58.00	05800	MRI	0.076040	3,178,390	0	0	241,685	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182182	0	0	0	0	59.00
60.00	06000	LABORATORY	0.209538	2,318,783	0	0	485,873	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.262758	160,025	0	0	42,048	65.00
66.00	06600	PHYSICAL THERAPY	0.266798	32,218	0	0	8,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229861	5,863	0	0	1,348	67.00
68.00	06800	SPEECH PATHOLOGY	0.338251	3,018	0	0	1,021	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055133	4,077,230	0	0	224,790	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.424722	1,259,862	0	0	535,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.256267	1,457,307	0	0	373,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.516989	1,887,030	0	0	975,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272706	2,613,583	0	31,767	712,740	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.877659	0	0	0	0	76.01
76.02	03952	WOUND CARE	0.337838	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.154742	69,942	0	0	10,823	90.02
91.00	09100	EMERGENCY	0.201556	2,276,666	0	0	458,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.701203	822,820	0	0	576,964	92.00
200.00		Subtotal (see instructions)		42,747,702	0	31,767	8,224,879	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,747,702	0	31,767	8,224,879	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	8,663	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	76.01
76.02	03952	WOUND CARE	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
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	8,663	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	8,663	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,316,026	0	2,316,026	12,100	191.41	30.00
31.00	INTENSIVE CARE UNIT	577,961		577,961	1,666	346.92	31.00
200.00	Total (lines 30 through 199)	2,893,987		2,893,987	13,766		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	681	130,350	30.00
31.00	INTENSIVE CARE UNIT	81	28,101	31.00
200.00	Total (lines 30 through 199)	762	158,451	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	964,670	46,158,617	0.020899	1,714,739	35,836	50.00
51.00	05100	RECOVERY ROOM	406,339	5,958,290	0.068197	109,223	7,449	51.00
53.00	05300	ANESTHESIOLOGY	10,977	12,846,256	0.000854	287,008	245	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,730	27,075,413	0.017017	247,704	4,215	54.00
57.00	05700	CT SCAN	25,630	26,989,151	0.000950	308,673	293	57.00
58.00	05800	MRI	20,740	17,822,008	0.001164	122,058	142	58.00
59.00	05900	CARDIAC CATHETERIZATION	827,759	16,991,972	0.048715	208,507	10,157	59.00
60.00	06000	LABORATORY	199,291	21,975,832	0.009069	632,062	5,732	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	86,635	4,614,151	0.018776	290,112	5,447	65.00
66.00	06600	PHYSICAL THERAPY	7,214	1,603,372	0.004499	88,896	400	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,401	358,895	0.003904	23,001	90	67.00
68.00	06800	SPEECH PATHOLOGY	902	157,540	0.005726	4,568	26	68.00
69.00	06900	ELECTROCARDIOLOGY	8,344	8,886,057	0.000939	137,115	129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	375,605	5,526,203	0.067968	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,083	14,344,180	0.003701	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,303	15,524,030	0.007299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,667	21,884,166	0.010677	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	126	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	5,135	347,906	0.014760	0	0	76.01
76.02	03952	WOUND CARE	2,270	402,083	0.005646	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	2	0	0.000000	0	0	90.01
90.02	09002	CLINIC	75,402	7,407,364	0.010179	0	0	90.02
91.00	09100	EMERGENCY	530,268	19,142,475	0.027701	370,760	10,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,758	4,657,135	0.121697	0	0	92.00
200.00		Total (lines 50 through 199)	4,976,251	280,673,096		4,544,426	80,431	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/31/2018 12:22 pm

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		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	12,100	0.00	681	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,666	0.00	81	31.00
200.00		Total (lines 30 through 199)		0	13,766		762	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0165

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

Worksheet D Part IV

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 12:22 pm

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		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	46,158,617	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,958,290	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,846,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,075,413	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	26,989,151	0.000000	57.00
58.00	05800	MRI	0	0	0	17,822,008	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,991,972	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	21,975,832	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,614,151	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,603,372	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	358,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	157,540	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,886,057	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,526,203	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,344,180	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,524,030	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,884,166	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	347,906	0.000000	76.01
76.02	03952	WOUND CARE	0	0	0	402,083	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	7,407,364	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,142,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,657,135	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	280,673,096		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,714,739	0	5,891,279	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	109,223	0	739,334	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	287,008	0	1,440,430	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	247,704	0	2,913,711	0	54.00
57.00	05700	CT SCAN	0.000000	308,673	0	2,582,325	0	57.00
58.00	05800	MRI	0.000000	122,058	0	2,353,223	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	208,507	0	507,577	0	59.00
60.00	06000	LABORATORY	0.000000	632,062	0	1,962,612	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.000000	290,112	0	148,655	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	88,896	0	16,435	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	23,001	0	4,306	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,568	0	2,870	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	137,115	0	581,446	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	594,975	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	1,029	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	0	0	1,348,069	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.000000	0	0	15,950	0	76.01
76.02	03952	WOUND CARE	0.000000	0	0	36,811	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	598,308	0	90.02
91.00	09100	EMERGENCY	0.000000	370,760	0	3,802,129	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)		4,544,426	0	25,541,474	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191032	5,891,279	0	0	1,125,423	50.00
51.00	05100	RECOVERY ROOM	0.462477	739,334	0	0	341,925	51.00
53.00	05300	ANESTHESIOLOGY	0.058063	1,440,430	0	0	83,636	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176772	2,913,711	0	0	515,063	54.00
57.00	05700	CT SCAN	0.059873	2,582,325	0	0	154,612	57.00
58.00	05800	MRI	0.076040	2,353,223	0	0	178,939	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182182	507,577	0	0	92,471	59.00
60.00	06000	LABORATORY	0.209538	1,962,612	0	0	411,242	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.262758	148,655	0	0	39,060	65.00
66.00	06600	PHYSICAL THERAPY	0.266798	16,435	0	0	4,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229861	4,306	0	0	990	67.00
68.00	06800	SPEECH PATHOLOGY	0.338251	2,870	0	0	971	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055133	581,446	0	0	32,057	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.424722	594,975	0	0	252,699	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.256267	1,029	0	0	264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.516989	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272706	1,348,069	0	0	367,627	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.877659	15,950	0	0	13,999	76.01
76.02	03952	WOUND CARE	0.337838	36,811	0	0	12,436	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.154742	598,308	0	0	92,583	90.02
91.00	09100	EMERGENCY	0.201556	3,802,129	0	0	766,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.701203	0	0	0	0	92.00
200.00		Subtotal (see instructions)		25,541,474	0	0	4,486,724	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,541,474	0	0	4,486,724	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	76.01
76.02	03952	WOUND CARE	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 12:22 pm

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)	12,100	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,100	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)	9,139	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)	4,662	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)	13,344,735	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)	13,344,735	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)	13,344,735	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)	1,102.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,141,580	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)	5,141,580	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 12:22 pm

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	3,240,239	1,666	1,944.92	547	1,063,871	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)	8,378,531	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,583,982	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,082,118	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	494,904	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,577,022	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,006,960	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,961	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,102.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,265,598	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 12:22 pm

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	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	2,316,026	13,344,735	0.173554	3,265,598	566,758	90.00
91.00	Nursing School cost	0	13,344,735	0.000000	3,265,598	0	91.00
92.00	Allied health cost	0	13,344,735	0.000000	3,265,598	0	92.00
93.00	All other Medical Education	0	13,344,735	0.000000	3,265,598	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/31/2018 12:22 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,100	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,100	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)	9,139	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)	681	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)	13,344,735	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)	13,344,735	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)	13,344,735	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)	1,102.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	751,054	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)	751,054	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,240,239	1,666	1,944.92	81	157,539	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)	826,477	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,735,070	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)	158,451	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	80,431	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	238,882	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,496,188	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,961	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,102.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,265,598	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,316,026	13,344,735	0.173554	3,265,598	566,758	90.00
91.00	Nursing School cost	0	13,344,735	0.000000	3,265,598	0	91.00
92.00	Allied health cost	0	13,344,735	0.000000	3,265,598	0	92.00
93.00	All other Medical Education	0	13,344,735	0.000000	3,265,598	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 12:22 pm

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		8,249,159		30.00
31.00	03100	INTENSIVE CARE UNIT		1,797,227		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191330	5,021,481	960,760	50.00
51.00	05100	RECOVERY ROOM	0.462477	460,508	212,974	51.00
53.00	05300	ANESTHESIOLOGY	0.058063	853,323	49,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176772	271,584	48,008	54.00
57.00	05700	CT SCAN	0.059873	2,044,578	122,415	57.00
58.00	05800	MRI	0.076040	675,128	51,337	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182291	375,258	68,406	59.00
60.00	06000	LABORATORY	0.209778	4,687,853	983,408	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.262758	2,091,144	549,465	65.00
66.00	06600	PHYSICAL THERAPY	0.266798	731,474	195,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229861	173,225	39,818	67.00
68.00	06800	SPEECH PATHOLOGY	0.338251	83,431	28,221	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055133	272,663	15,033	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.425864	327,026	139,269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.256267	1,462,765	374,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.516989	3,694,801	1,910,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272706	6,776,820	1,848,079	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.877659	44,257	38,843	76.01
76.02	03952	WOUND CARE	0.337838	2,798	945	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	CLINIC	0.154742	0	0	90.02
91.00	09100	EMERGENCY	0.201556	1,464,753	295,230	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.701203	636,890	446,589	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		32,151,760	8,378,531	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)		32,151,760		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,364,679		30.00
31.00	03100	INTENSIVE CARE UNIT		248,299		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191330	1,714,739	328,081	50.00
51.00	05100	RECOVERY ROOM	0.462477	109,223	50,513	51.00
53.00	05300	ANESTHESIOLOGY	0.058063	287,008	16,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176772	247,704	43,787	54.00
57.00	05700	CT SCAN	0.059873	308,673	18,481	57.00
58.00	05800	MRI	0.076040	122,058	9,281	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182291	208,507	38,009	59.00
60.00	06000	LABORATORY	0.209778	632,062	132,593	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.262758	290,112	76,229	65.00
66.00	06600	PHYSICAL THERAPY	0.266798	88,896	23,717	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.229861	23,001	5,287	67.00
68.00	06800	SPEECH PATHOLOGY	0.338251	4,568	1,545	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055133	137,115	7,560	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.425864	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.256267	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.516989	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272706	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.877659	0	0	76.01
76.02	03952	WOUND CARE	0.337838	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	CLINIC	0.154742	0	0	90.02
91.00	09100	EMERGENCY	0.201556	370,760	74,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.701203	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,544,426	826,477	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,544,426		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 12:22 pm
	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)	6,721,394	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,626,045	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)	1,080,740	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	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	54.89	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)	3.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)	7.05	31.00
32.00	Sum of lines 30 and 31	10.42	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/31/2018 12:22 pm

	Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000003292	0.000002600	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)	10,428,179		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,428,179	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	876,558	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	1,036	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)	11,305,773	59.00
60.00	Primary payer payments	4,485	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,301,288	61.00
62.00	Deductibles billed to program beneficiaries	1,017,016	62.00
63.00	Coinsurance billed to program beneficiaries	29,610	63.00
64.00	Allowable bad debts (see instructions)	88,975	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	57,834	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,190	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,312,496	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)	-41,331	70.93
70.94	HRR adjustment amount (see instructions)	-47,467	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/31/2018 12:22 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,223,698	71.00
71.01	Sequestration adjustment (see instructions)		204,474	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,962,546	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)		56,678	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		64,810	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2018 12:22 pm

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		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	6,721,394	0	6,721,394		6,721,394	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,626,045	0		2,626,045	2,626,045	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	1,080,740	0	1,038,257	42,483	1,080,740	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	0	0	0	0	0	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	10,428,179	0	7,759,651	2,668,528	10,428,179	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	10,428,179	0	7,759,651	2,668,528	10,428,179	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	876,558	0	654,612	221,946	876,558	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	1,036	0	1,036	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2018 12:22 pm

		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	8,415,299	2,890,474	11,305,773	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	758,037	0	544,121	213,916	758,037	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	118,521	0	110,491	8,030	118,521	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	876,558	0	654,612	221,946	876,558	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				0.189286	0.138214		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			1,592,898		1,592,898	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				399,504	399,504	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 | Date/Time Prepared: 5/31/2018 12:22 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,721,394	6,721,394		6,721,394	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,626,045		2,626,045	2,626,045	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,080,740	1,038,257	42,483	1,080,740	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	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	12.00
13.00	Subtotal (see instructions)	47.00	10,428,179	7,759,651	2,668,528	10,428,179	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,428,179	7,759,651	2,668,528	10,428,179	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	876,558	654,612	221,946	876,558	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	1,036	0	1,036	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,415,299	2,890,474	11,305,773	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2018 12:22 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	758,037	544,121	213,916	758,037	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	118,521	110,491	8,030	118,521	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	876,558	654,612	221,946	876,558	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-41,331	-27,337	-13,994	-41,331	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-47,467	-30,923	-16,544	-47,467	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		83,570	0	83,570	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part B | Date/Time Prepared: 5/31/2018 12:22 pm

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,663	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,224,879	2.00
3.00	OPPS payments	7,813,427	3.00
4.00	Outlier payment (see instructions)	56,381	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)	8,663	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	31,767	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)	31,767	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)	31,767	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	23,104	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)	8,663	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)	7,869,808	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)	1,560,661	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	6,317,810	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	6,317,810	30.00
31.00	Primary payer payments	4,867	31.00
32.00	Subtotal (line 30 minus line 31)	6,312,943	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)	169,407	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	110,115	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	70,526	36.00
37.00	Subtotal (see instructions)	6,423,058	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-313	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)	6,423,371	40.00
40.01	Sequestration adjustment (see instructions)	128,467	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,181,610	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	113,294	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2018 12:22 pm

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		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		9,962,546		6,181,610	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)		9,962,546		6,181,610	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		56,678		113,294	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,019,224		6,294,904	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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part II Date/Time Prepared: 5/31/2018 12:22 pm

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

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

Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/31/2018 12:22 pm

		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	137,082,253	0	0	0	1.00
2.00	Temporary investments	3,595,163	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,236,466	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,282,468	0	0	0	6.00
7.00	Inventory	1,757,830	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	179,623	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)	153,568,867	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,941,227	0	0	0	12.00
13.00	Land improvements	2,653,813	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	49,751,780	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	5,034,517	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	106,913,769	0	0	0	19.00
20.00	Accumulated depreciation	-34,124,205	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	0	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)	138,170,901	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,803,557	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,803,557	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	295,543,325	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,473,106	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,239,005	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	321,344	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	237,784	0	0	0	43.00
44.00	Other current liabilities	240,277,515	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	250,548,754	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	860,994	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	249,249	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,110,243	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	251,658,997	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,884,328				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)	43,884,328	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	295,543,325	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/31/2018 12:22 pm

		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		43,123,509		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,112,491				2.00
3.00	Total (sum of line 1 and line 2)		50,236,000		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)		50,236,000		0		11.00
12.00	EQUITY TRANSFERS	6,351,666		0		0	12.00
13.00	ROUNDING	6		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		6,351,672		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		43,884,328		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	EQUITY TRANSFERS		0		12.00
13.00	ROUNDING		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: 15-0165 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2018 12:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,826,813		17,826,813	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,826,813		17,826,813	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,980,507		4,980,507	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)	4,980,507		4,980,507	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,807,320		22,807,320	17.00
18.00	Ancillary services	72,592,186	176,873,936	249,466,122	18.00
19.00	Outpatient services	4,503,190	26,703,784	31,206,974	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 PRIVATE OFFICES	0	1,327,165	1,327,165	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	99,902,696	204,904,885	304,807,581	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		75,049,385		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)		75,049,385		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/31/2018 12:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	304,807,581	1.00
2.00	Less contractual allowances and discounts on patients' accounts	223,630,611	2.00
3.00	Net patient revenues (line 1 minus line 2)	81,176,970	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	75,049,385	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,127,585	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	78,605	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	906,301	24.00
25.00	Total other income (sum of lines 6-24)	984,906	25.00
26.00	Total (line 5 plus line 25)	7,112,491	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,112,491	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0165	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/31/2018 12:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	758,037	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	118,521	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)	29.60	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)	876,558	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