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: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 2:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 2:01 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 INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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	-987,422	-959,278	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	-25,652	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-1,013,074	-959,278	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2018 10:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2018 10:35 am

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

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2018 10:35 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2018 10:35 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/27/2018 10:35 am

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	72,313	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2018 10:35 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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.	Y	11/27/2017	146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2017	06/30/2017	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)	Y	95	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2018 10:35 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/22/2018	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.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	04/04/2018	Y	04/04/2018 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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2018 10:35 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/27/2018 10:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2018 10:35 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,935	61,440.00	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)		19	6,935	61,440.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	20,040.00	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)		25	9,125	81,480.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2018 10:35 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,559	27	2,554			1.00
2.00	HMO and other (see instructions)	401	285				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	318	0	318			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	49			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,877	27	2,921			7.00
8.00	INTENSIVE CARE UNIT	518	14	835			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)	2,395	41	3,756	0.00	212.00	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	6			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	212.00	27.00
28.00	Observation Bed Days		13	1,324			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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2018 10:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	556	11	950	1.00
2.00	HMO and other (see instructions)			107	77		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	556	11	950	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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/27/2018 10:35 am

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.237067	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,113,241	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			28,973,322	6.00
7.00	Medicaid cost (line 1 times line 6)			6,868,619	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)			3,755,378	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)			3,755,378	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)	2,865,016	159,313	3,024,329	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	679,201	159,313	838,514	21.00
22.00	Payments received from patients for amounts previously written off as charity care	47,723	0	47,723	22.00
23.00	Cost of charity care (line 21 minus line 22)	631,478	159,313	790,791	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?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,213,555	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			571,741	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			879,602	27.01
28.00	Non-Medicare bad debt expense (see instructions)			4,333,953	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,335,298	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,126,089	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,881,467	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	620,566	620,566	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	978,838	978,838	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,393	372,814	387,207	2,252,616	2,639,823	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,187,321	13,906,328	15,093,649	-381,363	14,712,286	5.00
7.00	00700	OPERATION OF PLANT	364,363	1,674,606	2,038,969	-305,971	1,732,998	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,135	99,135	-1,266	97,869	8.00
9.00	00900	HOUSEKEEPING	362,641	328,208	690,849	-164,503	526,346	9.00
10.00	01000	DIETARY	359,998	275,304	635,302	-234,455	400,847	10.00
11.00	01100	CAFETERIA	0	0	0	146,674	146,674	11.00
13.00	01300	NURSING ADMINISTRATION	1,223,419	526,992	1,750,411	-193,379	1,557,032	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,850	83,281	130,131	887,218	1,017,349	14.00
15.00	01500	PHARMACY	414,775	7,952,595	8,367,370	-7,487,890	879,480	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	42,575	42,575	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,970,659	1,144,161	3,114,820	-496,760	2,618,060	30.00
31.00	03100	INTENSIVE CARE UNIT	889,291	475,714	1,365,005	-275,652	1,089,353	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	817,590	1,602,414	2,420,004	-810,189	1,609,815	50.00
51.00	05100	RECOVERY ROOM	319,526	78,988	398,514	-68,726	329,788	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,247	1,067,413	2,665,660	-603,198	2,062,462	54.00
56.00	05600	RADIOISOTOPE	65,147	336,899	402,046	-241,179	160,867	56.00
57.00	05700	CT SCAN	228,670	318,297	546,967	-202,287	344,680	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	140,789	204,910	345,699	-48,333	297,366	58.00
60.00	06000	LABORATORY	276,737	4,008,443	4,285,180	-31,953	4,253,227	60.00
65.00	06500	RESPIRATORY THERAPY	580,367	257,876	838,243	-213,649	624,594	65.00
66.00	06600	PHYSICAL THERAPY	596,960	162,999	759,959	-98,833	661,126	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,231	48,151	348,382	-26,956	321,426	67.00
68.00	06800	SPEECH PATHOLOGY	67,627	18,820	86,447	-16,500	69,947	68.00
69.00	06900	ELECTROCARDIOLOGY	271,365	526,221	797,586	-177,451	620,135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	183,970	183,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	107,571	107,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,600,038	7,600,038	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	75,921	75,921	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	97,053	97,053	-194	96,859	90.01
91.00	09100	EMERGENCY	1,657,728	1,379,541	3,037,269	-475,687	2,561,582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,754,694	36,947,163	50,701,857	339,613	51,041,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,087	12,690	22,777	-12,035	10,742	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	270,764	270,764	-270,764	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	20,354	20,354	-5,793	14,561	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	152,034	73,118	225,152	-50,980	174,172	194.02
194.03	07953	HOME CARE	0	41	41	-41	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,916,815	37,324,130	51,240,945	0	51,240,945	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	112,751	733,317		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	75,071	1,053,909		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-250,109	2,389,714		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,742,695	10,969,591		5.00
7.00	00700	OPERATION OF PLANT	-8,396	1,724,602		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,035	95,834		8.00
9.00	00900	HOUSEKEEPING	-3,307	523,039		9.00
10.00	01000	DIETARY	0	400,847		10.00
11.00	01100	CAFETERIA	-101,444	45,230		11.00
13.00	01300	NURSING ADMINISTRATION	-53,054	1,503,978		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,017,349		14.00
15.00	01500	PHARMACY	0	879,480		15.00
17.00	01700	SOCIAL SERVICE	0	42,575		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-327,981	2,290,079		30.00
31.00	03100	INTENSIVE CARE UNIT	-87,470	1,001,883		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-906,277	703,538		50.00
51.00	05100	RECOVERY ROOM	0	329,788		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-910	2,061,552		54.00
56.00	05600	RADIOISOTOPE	0	160,867		56.00
57.00	05700	CT SCAN	0	344,680		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	297,366		58.00
60.00	06000	LABORATORY	-235,226	4,018,001		60.00
65.00	06500	RESPIRATORY THERAPY	-28,229	596,365		65.00
66.00	06600	PHYSICAL THERAPY	-15,507	645,619		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	321,426		67.00
68.00	06800	SPEECH PATHOLOGY	0	69,947		68.00
69.00	06900	ELECTROCARDIOLOGY	-1,662	618,473		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,970		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	107,571		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,600,038		73.00
76.97	07697	CARDIAC REHABILITATION	0	75,921		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	-120	96,739		90.01
91.00	09100	EMERGENCY	-82,281	2,479,301		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,658,881	45,382,589		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,742		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	-14,216	345		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	174,172		194.02
194.03	07953	HOME CARE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,673,097	45,567,848		200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/27/2018 10:35 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,202,044	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	2,202,044	
	B - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	77,895	68,779	1.00
	0		77,895	68,779	
	C - CAPITAL LEASE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	21,731	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,483	2.00
3.00		0.00	0	0	3.00
	0		0	24,214	
	D - CARDIOLOGY				
1.00	CARDIAC REHABILITATION	76.97	61,751	14,170	1.00
	0		61,751	14,170	
	E - DEPR EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	612,227	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	973,304	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	1,585,531	
	F - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,600,038	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

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/27/2018 10:35 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	7,600,038		
	G - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	107,571		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
	0		0	107,571		
	H - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52,299		1.00
2.00	HOUSEKEEPING	9.00	0	3,532		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	420		3.00
4.00	PHARMACY	15.00	0	8,376		4.00
5.00	OPERATING ROOM	50.00	0	907		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	711		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	134		7.00
8.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	4,518		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
	0		0	70,897		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	PHARMACY	15.00	0	51		1.00
2.00	LABORATORY	60.00	0	1,141		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	183,970		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
	0		0	185,162		
	J - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	43,673		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,975		2.00
	0		0	51,648		
	K - PROPERTY TAXES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,065		1.00
	0		0	57,065		
	L - SOCIAL WORKER					
1.00	SOCIAL SERVICE	17.00	42,575	0		1.00
	0		42,575	0		
	N - NON-BILLABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	915,748		1.00
2.00	LABORATORY	60.00	0	1,862		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
	TOTALS		0	917,610		

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/27/2018 10:35 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	O - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	13,334	1.00
2.00	RADIOISOTOPE	56.00	0	38	2.00
3.00	CT SCAN	57.00	0	1,645	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
	TOTALS		0	15,017	
500.00	Grand Total: Increases		182,221	12,899,746	500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/27/2018 10:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	123,157	0		1.00
2.00	OPERATION OF PLANT	7.00	0	77,898	0		2.00
3.00	HOUSEKEEPING	9.00	0	130,926	0		3.00
4.00	DIETARY	10.00	0	68,754	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	176,953	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,319	0		6.00
7.00	PHARMACY	15.00	0	44,525	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	342,644	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	142,853	0		9.00
10.00	OPERATING ROOM	50.00	0	128,528	0		10.00
11.00	RECOVERY ROOM	51.00	0	56,905	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	284,122	0		12.00
13.00	RADIOISOTOPE	56.00	0	13,261	0		13.00
14.00	CT SCAN	57.00	0	9,665	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,078	0		15.00
16.00	LABORATORY	60.00	0	22,311	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	102,943	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	78,620	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	24,023	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	13,644	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	33,826	0		21.00
22.00	EMERGENCY	91.00	0	251,076	0		22.00
23.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	11,656	0		23.00
24.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	44,357	0		24.00
	0		0	2,202,044			
	B - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	77,895	68,779	0		1.00
	0		77,895	68,779			
	C - CAPITAL LEASE						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,441	9		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,731	0		3.00
	0		0	24,214			
	D - CARDIOLOGY						
1.00	ELECTROCARDIOLOGY	69.00	61,751	14,170	0		1.00
	0		61,751	14,170			
	E - DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,727	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	213,266	9		2.00
3.00	OPERATION OF PLANT	7.00	0	222,505	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,266	0		4.00
5.00	HOUSEKEEPING	9.00	0	1,524	0		5.00
6.00	DIETARY	10.00	0	16,567	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	8,839	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,131	0		8.00
9.00	PHARMACY	15.00	0	41,622	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	36,274	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	90,909	0		11.00
12.00	OPERATING ROOM	50.00	0	95,508	0		12.00
13.00	RECOVERY ROOM	51.00	0	265	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	213,660	0		14.00
15.00	RADIOISOTOPE	56.00	0	86,934	0		15.00
16.00	CT SCAN	57.00	0	113,980	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	26,567	0		17.00
18.00	LABORATORY	60.00	0	12,645	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	18,034	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	11,018	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	21,133	0		21.00
22.00	CLINIC - DIABETES	90.01	0	194	0		22.00
23.00	EMERGENCY	91.00	0	70,976	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	249,033	0		24.00
25.00	OCCUPATIONAL HEALTH	194.00	0	5,793	0		25.00
26.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	11,120	0		26.00
27.00	HOME CARE	194.03	0	41	0		27.00
	0		0	1,585,531			

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/27/2018 10:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	F - BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	7,416,233	0		1.00
2.00	OPERATING ROOM	50.00	0	212	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53	0		3.00
4.00	RADIOISOTOPE	56.00	0	131,084	0		4.00
5.00	CT SCAN	57.00	0	37,827	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	14,629	0		6.00
	0		0	7,600,038			
	G - IMPLANT SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	244	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,640	0		2.00
3.00	OPERATING ROOM	50.00	0	105,680	0		3.00
4.00	EMERGENCY	91.00	0	7	0		4.00
	0		0	107,571			
	H - ACCRUED PTO						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,558	0		1.00
2.00	OPERATION OF PLANT	7.00	0	5,464	0		2.00
3.00	DIETARY	10.00	0	107	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	7,181	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,918	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	954	0		6.00
7.00	RECOVERY ROOM	51.00	0	11,556	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,923	0		8.00
9.00	RADIOISOTOPE	56.00	0	2,455	0		9.00
10.00	CT SCAN	57.00	0	235	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	9,257	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	2,476	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	2,933	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	2,856	0		14.00
15.00	EMERGENCY	91.00	0	5,645	0		15.00
16.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	379	0		16.00
	0		0	70,897			
	I - BILLABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,256	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	7,096	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	213	0		3.00
4.00	OPERATING ROOM	50.00	0	158,601	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,389	0		5.00
6.00	CT SCAN	57.00	0	1,672	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	568	0		7.00
8.00	EMERGENCY	91.00	0	9,367	0		8.00
	0		0	185,162			
	J - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,648	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	51,648			
	K - PROPERTY TAXES						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	57,065	9		1.00
	0		0	57,065			
	L - SOCIAL WORKER						
1.00	ADMINISTRATIVE & GENERAL	5.00	42,575	0	0		1.00
	0		42,575	0			
	N - NON-BILLABLE SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,707	0		1.00
2.00	OPERATION OF PLANT	7.00	0	104	0		2.00
3.00	HOUSEKEEPING	9.00	0	35,585	0		3.00
4.00	DIETARY	10.00	0	2,353	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	406	0		5.00
6.00	PHARMACY	15.00	0	7,271	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	102,560	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	39,226	0		8.00
9.00	OPERATING ROOM	50.00	0	321,208	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,069	0		10.00
11.00	RADIOISOTOPE	56.00	0	7,483	0		11.00
12.00	CT SCAN	57.00	0	40,553	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,770	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	82,606	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	6,719	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	46,540	0		16.00
17.00	EMERGENCY	91.00	0	135,429	0		17.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/27/2018 10:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
18.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	21	0		18.00
	TOTALS		0	917,610			
	O - NON-BILLABLE DRUGS						
1.00	ADULTS & PEDIATRICS	30.00	0	3,628	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,497	0		2.00
3.00	OPERATING ROOM	50.00	0	1,359	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,940	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	241	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	165	0		6.00
7.00	EMERGENCY	91.00	0	3,187	0		7.00
	TOTALS		0	15,017			
500.00	Grand Total: Decreases		182,221	12,899,746			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2018 10:35 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	931,334	0	0	0	0	1.00
2.00	Land Improvements	1,119,735	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,929,250	0	0	0	0	3.00
4.00	Building Improvements	5,027,624	95,375	0	95,375	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,114,864	821,614	0	821,614	2,478,276	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,122,807	916,989	0	916,989	2,478,276	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,122,807	916,989	0	916,989	2,478,276	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	931,334	0	1.00
2.00	Land Improvements	1,119,735	0	2.00
3.00	Buildings and Fixtures	14,929,250	0	3.00
4.00	Building Improvements	5,122,999	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,458,202	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,561,520	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	41,561,520	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/27/2018 10:35 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2018 10:35 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	22,103,318	639,150	21,464,168	0.525710	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	19,458,202	93,477	19,364,725	0.474290	0	2.00
3.00	Total (sum of lines 1-2)	41,561,520	732,627	40,828,893	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	755,048	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,051,469	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,806,517	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-21,731	0	0	0	733,317	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,440	0	0	0	1,053,909	2.00
3.00	Total (sum of lines 1-2)	-19,291	0	0	0	1,787,226	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/27/2018 10:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-21,731	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	2,440	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-3,525,796			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	2,344,266			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/27/2018 10:35 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-131,034	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-27,735	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	MISCELLANEOUS INCOME	B	-6,658	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-2,035	LAUNDRY & LINEN SERVICE	8.00	0	35.00
37.00	MISCELLANEOUS INCOME	B	-3,307	HOUSEKEEPING	9.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-101,444	CAFETERIA	11.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-53,054	NURSING ADMINISTRATION	13.00	0	39.00
40.00	MISCELLANEOUS INCOME	B	-5,475	INTENSIVE CARE UNIT	31.00	0	40.00
41.00	MISCELLANEOUS INCOME	B	-910	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	MISCELLANEOUS INCOME	B	-28,229	RESPIRATORY THERAPY	65.00	0	42.00
43.00	MISCELLANEOUS INCOME	B	-1,575	ELECTROCARDIOLOGY	69.00	0	43.00
45.00	MISCELLANEOUS INCOME	B	-120	CLINIC - DIABETES	90.01	0	45.00
45.01	PHONES	A	-8	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.01
45.02	PHONES	A	-2,935	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03	PHONES	A	-4,588	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PHONES	A	-20,555	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	HAF	A	-1,614,438	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	CABLE	A	-1,738	OPERATION OF PLANT	7.00	0	45.06
45.07	CABLE	A	-15,279	PHYSICAL THERAPY	66.00	0	45.07
45.08	RECRUITING	A	-29,452	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	BENEFITS	A	-2,326,957	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.09
45.10	ACCRUED PTO	A	-66,692	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.11	TELEPHONE EQUIPMENT	A	-228	PHYSICAL THERAPY	66.00	0	45.11
45.12	MARKETING	A	-21,098	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	MARKETING	A	-87	ELECTROCARDIOLOGY	69.00	0	45.13
45.14	MARKETING	A	-14,216	OCCUPATIONAL HEALTH	194.00	0	45.14
45.15	INVESTMENT FEES	B	7,571	ADMINISTRATIVE & GENERAL	5.00	0	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,673,097				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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2018 10:35 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HO ALLOCATIONS CAPITAL COSTS	134,490	0	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	HO ALLOCATIONS CAPITAL COSTS	206,600	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATIONS EMPLOYEE BENE	2,374,860	226,732	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HO ALLOCATION CORPORATE ADMI	9,650,640	11,494,045	3.01
4.00	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	75,567	75,567	4.00
4.01	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	210,077	210,077	4.01
4.02	15.00	PHARMACY	SHARED EMPLOYEES	491,991	491,991	4.02
4.03	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	482,222	482,222	4.03
4.04	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	120,555	120,555	4.04
4.05	50.00	OPERATING ROOM	SHARED EMPLOYEES	267	267	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	53,067	53,067	4.06
4.07	60.00	LABORATORY	SHARED EMPLOYEES	3,790,367	3,790,367	4.07
4.08	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	370,464	370,464	4.08
4.09	90.01	CLINIC - DIABETES	SHARED EMPLOYEES	96,273	96,273	4.09
4.10	91.00	EMERGENCY	BLOOMINGTON ER	2,368,272	669,819	4.10
5.00	0		0	20,425,712	18,081,446	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2018 10:35 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	134,490	9		1.00
2.00	206,600	9		2.00
3.00	2,148,128	0		3.00
3.01	-1,843,405	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	1,698,453	0		4.10
5.00	2,344,266			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HEALTHCARE		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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2018 10:35 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	193,583	193,583	0	0	0	1.00
2.00	50.00	OPERATING ROOM	906,277	906,277	0	0	0	2.00
3.00	60.00	LABORATORY	276,737	235,226	41,511	0	0	3.00
4.00	91.00	EMERGENCY	2,095,903	1,780,734	315,169	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	482,222	327,981	154,241	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	120,555	81,995	38,560	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,075,277	3,525,796	549,481		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	193,583		1.00
2.00	50.00	OPERATING ROOM	0	0	0	906,277		2.00
3.00	60.00	LABORATORY	0	0	0	235,226		3.00
4.00	91.00	EMERGENCY	0	0	0	1,780,734		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	327,981		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	81,995		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,525,796		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	733,317	733,317				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,053,909		1,053,909			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,389,714	1,933	3,864	2,395,511		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,969,591	115,383	230,640	197,250	11,512,864	5.00
7.00	00700	OPERATION OF PLANT	1,724,602	77,332	154,579	62,783	2,019,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,834	2,916	5,829	0	104,579	8.00
9.00	00900	HOUSEKEEPING	523,039	6,774	13,541	62,486	605,840	9.00
10.00	01000	DIETARY	400,847	14,649	29,283	48,609	493,388	10.00
11.00	01100	CAFETERIA	45,230	9,668	19,325	13,422	87,645	11.00
13.00	01300	NURSING ADMINISTRATION	1,503,978	19,442	38,862	210,806	1,773,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,017,349	3,949	7,893	8,073	1,037,264	14.00
15.00	01500	PHARMACY	879,480	5,450	10,895	71,469	967,294	15.00
17.00	01700	SOCIAL SERVICE	42,575	0	0	7,336	49,911	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,290,079	43,317	86,585	339,563	2,759,544	30.00
31.00	03100	INTENSIVE CARE UNIT	1,001,883	11,975	23,937	153,233	1,191,028	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	703,538	56,082	112,103	140,878	1,012,601	50.00
51.00	05100	RECOVERY ROOM	329,788	0	0	55,057	384,845	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,552	49,819	99,582	275,392	2,486,345	54.00
56.00	05600	RADIOISOTOPE	160,867	0	0	11,225	172,092	56.00
57.00	05700	CT SCAN	344,680	4,112	8,218	39,402	396,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	297,366	3,941	7,878	24,259	333,444	58.00
60.00	06000	LABORATORY	4,018,001	17,815	35,611	47,684	4,119,111	60.00
65.00	06500	RESPIRATORY THERAPY	596,365	4,732	9,458	100,002	710,557	65.00
66.00	06600	PHYSICAL THERAPY	645,619	12,834	25,653	102,862	786,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	321,426	4,656	9,307	51,733	387,122	67.00
68.00	06800	SPEECH PATHOLOGY	69,947	1,778	3,554	11,653	86,932	68.00
69.00	06900	ELECTROCARDIOLOGY	618,473	14,067	28,118	36,118	696,776	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,970	0	0	0	183,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	107,571	0	0	0	107,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,600,038	0	0	0	7,600,038	73.00
76.97	07697	CARDIAC REHABILITATION	75,921	8,503	16,996	10,640	112,060	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	96,739	1,982	3,962	0	102,683	90.01
91.00	09100	EMERGENCY	2,479,301	20,769	41,516	285,641	2,827,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,382,589	513,878	1,027,189	2,367,576	45,108,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,742	3,525	7,047	1,738	23,052	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	181,543	0	0	181,543	192.00
194.00	07950	OCCUPATIONAL HEALTH	345	9,842	19,673	0	29,860	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	174,172	24,529	0	26,197	224,898	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,567,848	733,317	1,053,909	2,395,511	45,567,848	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,512,864					5.00
7.00	00700	OPERATION OF PLANT	682,657	2,701,953				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,355	14,628	154,562			8.00
9.00	00900	HOUSEKEEPING	204,815	33,980	0	844,635		9.00
10.00	01000	DIETARY	166,798	73,481	0	38,319	771,986	10.00
11.00	01100	CAFETERIA	29,630	48,494	0	25,289	0	11.00
13.00	01300	NURSING ADMINISTRATION	599,423	97,519	0	50,854	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	350,665	19,807	0	10,329	0	14.00
15.00	01500	PHARMACY	327,010	27,340	0	14,257	0	15.00
17.00	01700	SOCIAL SERVICE	16,873	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	932,911	217,275	52,936	113,304	582,119	30.00
31.00	03100	INTENSIVE CARE UNIT	402,647	60,067	24,869	31,324	189,867	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	342,327	281,308	27,163	146,696	0	50.00
51.00	05100	RECOVERY ROOM	130,103	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	840,551	249,889	0	130,311	0	54.00
56.00	05600	RADIOISOTOPE	58,179	0	0	0	0	56.00
57.00	05700	CT SCAN	134,014	20,623	0	10,755	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,726	19,770	0	10,309	0	58.00
60.00	06000	LABORATORY	1,392,535	89,361	0	46,600	0	60.00
65.00	06500	RESPIRATORY THERAPY	240,216	23,735	0	12,377	0	65.00
66.00	06600	PHYSICAL THERAPY	266,048	64,374	0	33,570	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,873	23,355	0	12,179	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,389	8,917	0	4,650	0	68.00
69.00	06900	ELECTROCARDIOLOGY	235,557	70,559	0	36,795	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,194	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,366	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,569,319	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	37,884	42,651	0	22,241	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	34,714	9,942	0	5,184	0	90.01
91.00	09100	EMERGENCY	955,792	104,179	49,594	54,327	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,357,571	1,601,254	154,562	809,670	771,986	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,793	17,683	0	9,221	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,374	910,611	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	10,095	49,367	0	25,744	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	76,031	123,038	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,512,864	2,701,953	154,562	844,635	771,986	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	191,058					11.00
13.00	01300	NURSING ADMINISTRATION	14,152	2,535,036				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,022	0	1,420,087			14.00
15.00	01500	PHARMACY	6,065	0	18,555	1,360,521		15.00
17.00	01700	SOCIAL SERVICE	1,011	0	0	0	67,795	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,369	993,461	111,317	65	51,091	30.00
31.00	03100	INTENSIVE CARE UNIT	11,120	342,572	40,378	27	16,704	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,098	102,772	351,207	24	0	50.00
51.00	05100	RECOVERY ROOM	4,044	137,029	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,261	239,801	86,428	88	0	54.00
56.00	05600	RADIOISOTOPE	1,011	0	7,697	0	0	56.00
57.00	05700	CT SCAN	4,044	0	41,712	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,022	0	1,821	0	0	58.00
60.00	06000	LABORATORY	21,229	0	173,169	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,098	0	86,114	4	0	65.00
66.00	06600	PHYSICAL THERAPY	9,098	34,257	6,916	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,033	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,011	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,033	68,514	48,425	3	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	189,230	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	110,647	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,360,253	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,011	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	24,261	616,630	146,449	57	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,993	2,535,036	1,420,065	1,360,521	67,795	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,011	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,054	0	22	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	191,058	2,535,036	1,420,087	1,360,521	67,795	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,848,392	0	5,848,392		30.00
31.00	03100	INTENSIVE CARE UNIT	2,310,603	0	2,310,603		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,273,196	0	2,273,196		50.00
51.00	05100	RECOVERY ROOM	656,021	0	656,021		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,674	0	4,057,674		54.00
56.00	05600	RADIOISOTOPE	238,979	0	238,979		56.00
57.00	05700	CT SCAN	607,560	0	607,560		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	480,092	0	480,092		58.00
60.00	06000	LABORATORY	5,842,005	0	5,842,005		60.00
65.00	06500	RESPIRATORY THERAPY	1,082,101	0	1,082,101		65.00
66.00	06600	PHYSICAL THERAPY	1,201,231	0	1,201,231		66.00
67.00	06700	OCCUPATIONAL THERAPY	556,562	0	556,562		67.00
68.00	06800	SPEECH PATHOLOGY	130,899	0	130,899		68.00
69.00	06900	ELECTROCARDIOLOGY	1,159,662	0	1,159,662		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	435,394	0	435,394		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	254,584	0	254,584		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,529,610	0	11,529,610		73.00
76.97	07697	CARDIAC REHABILITATION	215,847	0	215,847		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	152,523	0	152,523		90.01
91.00	09100	EMERGENCY	4,778,516	0	4,778,516		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,811,451	0	43,811,451		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58,760	0	58,760		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,153,528	0	1,153,528		192.00
194.00	07950	OCCUPATIONAL HEALTH	115,066	0	115,066		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	429,043	0	429,043		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	45,567,848	0	45,567,848		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,933	3,864	5,797	5,797	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	115,383	230,640	346,023	477	5.00
7.00	00700	OPERATION OF PLANT	0	77,332	154,579	231,911	152	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,916	5,829	8,745	0	8.00
9.00	00900	HOUSEKEEPING	0	6,774	13,541	20,315	151	9.00
10.00	01000	DIETARY	0	14,649	29,283	43,932	118	10.00
11.00	01100	CAFETERIA	0	9,668	19,325	28,993	32	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,442	38,862	58,304	510	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,949	7,893	11,842	20	14.00
15.00	01500	PHARMACY	0	5,450	10,895	16,345	173	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	18	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	43,317	86,585	129,902	824	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,975	23,937	35,912	371	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	56,082	112,103	168,185	341	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	133	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,819	99,582	149,401	666	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	27	56.00
57.00	05700	CT SCAN	0	4,112	8,218	12,330	95	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,941	7,878	11,819	59	58.00
60.00	06000	LABORATORY	0	17,815	35,611	53,426	115	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,732	9,458	14,190	242	65.00
66.00	06600	PHYSICAL THERAPY	0	12,834	25,653	38,487	249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,656	9,307	13,963	125	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,778	3,554	5,332	28	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,067	28,118	42,185	87	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	8,503	16,996	25,499	26	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	1,982	3,962	5,944	0	90.01
91.00	09100	EMERGENCY	0	20,769	41,516	62,285	691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	513,878	1,027,189	1,541,067	5,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,525	7,047	10,572	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	181,543	0	181,543	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	9,842	19,673	29,515	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	24,529	0	24,529	63	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	733,317	1,053,909	1,787,226	5,797	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	346,500					5.00
7.00	00700	OPERATION OF PLANT	20,546	252,609				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,064	1,368	11,177			8.00
9.00	00900	HOUSEKEEPING	6,164	3,177	0	29,807		9.00
10.00	01000	DIETARY	5,020	6,870	0	1,352	57,292	10.00
11.00	01100	CAFETERIA	892	4,534	0	892	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,041	9,117	0	1,795	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,554	1,852	0	365	0	14.00
15.00	01500	PHARMACY	9,842	2,556	0	503	0	15.00
17.00	01700	SOCIAL SERVICE	508	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,078	20,313	3,829	3,998	43,201	30.00
31.00	03100	INTENSIVE CARE UNIT	12,119	5,616	1,798	1,105	14,091	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,303	26,300	1,964	5,177	0	50.00
51.00	05100	RECOVERY ROOM	3,916	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,299	23,362	0	4,599	0	54.00
56.00	05600	RADIOISOTOPE	1,751	0	0	0	0	56.00
57.00	05700	CT SCAN	4,033	1,928	0	380	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,393	1,848	0	364	0	58.00
60.00	06000	LABORATORY	41,912	8,354	0	1,645	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,230	2,219	0	437	0	65.00
66.00	06600	PHYSICAL THERAPY	8,007	6,018	0	1,185	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,939	2,184	0	430	0	67.00
68.00	06800	SPEECH PATHOLOGY	885	834	0	164	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,090	6,597	0	1,298	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,872	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,095	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,321	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,140	3,987	0	785	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	1,045	929	0	183	0	90.01
91.00	09100	EMERGENCY	28,767	9,740	3,586	1,917	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	341,826	149,703	11,177	28,574	57,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	235	1,653	0	325	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,847	85,135	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	304	4,615	0	908	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	2,288	11,503	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	346,500	252,609	11,177	29,807	57,292	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	35,343					11.00
13.00	01300	NURSING ADMINISTRATION	2,618	90,385				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	374	0	25,007			14.00
15.00	01500	PHARMACY	1,122	0	327	30,868		15.00
17.00	01700	SOCIAL SERVICE	187	0	0	0	713	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,358	35,421	1,960	1	537	30.00
31.00	03100	INTENSIVE CARE UNIT	2,057	12,214	711	1	176	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,683	3,664	6,185	1	0	50.00
51.00	05100	RECOVERY ROOM	748	4,886	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,488	8,550	1,522	2	0	54.00
56.00	05600	RADIOISOTOPE	187	0	136	0	0	56.00
57.00	05700	CT SCAN	748	0	735	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	374	0	32	0	0	58.00
60.00	06000	LABORATORY	3,927	0	3,049	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,683	0	1,516	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,683	1,221	122	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	561	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	187	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	561	2,443	853	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,332	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,948	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,862	0	73.00
76.97	07697	CARDIAC REHABILITATION	187	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,488	21,986	2,579	1	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,221	90,385	25,007	30,868	713	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	187	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	935	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,343	90,385	25,007	30,868	713	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	274,422	0	274,422		30.00
31.00	03100	INTENSIVE CARE UNIT	86,171	0	86,171		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	223,803	0	223,803		50.00
51.00	05100	RECOVERY ROOM	9,683	0	9,683		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,889	0	217,889		54.00
56.00	05600	RADIOISOTOPE	2,101	0	2,101		56.00
57.00	05700	CT SCAN	20,249	0	20,249		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,889	0	17,889		58.00
60.00	06000	LABORATORY	112,428	0	112,428		60.00
65.00	06500	RESPIRATORY THERAPY	27,517	0	27,517		65.00
66.00	06600	PHYSICAL THERAPY	56,972	0	56,972		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,202	0	21,202		67.00
68.00	06800	SPEECH PATHOLOGY	7,430	0	7,430		68.00
69.00	06900	ELECTROCARDIOLOGY	61,114	0	61,114		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,204	0	5,204		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,043	0	3,043		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,183	0	108,183		73.00
76.97	07697	CARDIAC REHABILITATION	31,624	0	31,624		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	8,101	0	8,101		90.01
91.00	09100	EMERGENCY	136,040	0	136,040		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,431,065	0	1,431,065		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,976	0	12,976		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	268,525	0	268,525		192.00
194.00	07950	OCCUPATIONAL HEALTH	35,342	0	35,342		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	39,318	0	39,318		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,787,226	0	1,787,226		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	193,874					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		139,393				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	511	511	13,902,422			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,505	30,505	1,144,746	-11,512,864	34,054,984	5.00
7.00	00700	OPERATION OF PLANT	20,445	20,445	364,363	0	2,019,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	771	771	0	0	104,579	8.00
9.00	00900	HOUSEKEEPING	1,791	1,791	362,641	0	605,840	9.00
10.00	01000	DIETARY	3,873	3,873	282,103	0	493,388	10.00
11.00	01100	CAFETERIA	2,556	2,556	77,895	0	87,645	11.00
13.00	01300	NURSING ADMINISTRATION	5,140	5,140	1,223,419	0	1,773,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,044	1,044	46,850	0	1,037,264	14.00
15.00	01500	PHARMACY	1,441	1,441	414,775	0	967,294	15.00
17.00	01700	SOCIAL SERVICE	0	0	42,575	0	49,911	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,452	11,452	1,970,659	0	2,759,544	30.00
31.00	03100	INTENSIVE CARE UNIT	3,166	3,166	889,291	0	1,191,028	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,827	14,827	817,590	0	1,012,601	50.00
51.00	05100	RECOVERY ROOM	0	0	319,526	0	384,845	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,171	13,171	1,598,247	0	2,486,345	54.00
56.00	05600	RADIOISOTOPE	0	0	65,147	0	172,092	56.00
57.00	05700	CT SCAN	1,087	1,087	228,670	0	396,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,042	1,042	140,789	0	333,444	58.00
60.00	06000	LABORATORY	4,710	4,710	276,737	0	4,119,111	60.00
65.00	06500	RESPIRATORY THERAPY	1,251	1,251	580,367	0	710,557	65.00
66.00	06600	PHYSICAL THERAPY	3,393	3,393	596,960	0	786,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,231	1,231	300,231	0	387,122	67.00
68.00	06800	SPEECH PATHOLOGY	470	470	67,627	0	86,932	68.00
69.00	06900	ELECTROCARDIOLOGY	3,719	3,719	209,614	0	696,776	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	183,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	107,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,600,038	73.00
76.97	07697	CARDIAC REHABILITATION	2,248	2,248	61,751	0	112,060	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	524	524	0	0	102,683	90.01
91.00	09100	EMERGENCY	5,491	5,491	1,657,728	0	2,827,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,859	135,859	13,740,301	-11,512,864	33,595,631	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	932	932	10,087	0	23,052	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,996	0	0	0	181,543	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,602	2,602	0	0	29,860	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,485	0	152,034	0	224,898	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	733,317	1,053,909	2,395,511		11,512,864	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.782441	7.560702	0.172309		0.338067	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,797		346,500	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000417		0.010175	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	142,413					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	771	228,208				8.00
9.00	00900	HOUSEKEEPING	1,791	0	85,370			9.00
10.00	01000	DIETARY	3,873	0	3,873	44,465		10.00
11.00	01100	CAFETERIA	2,556	0	2,556	0	189	11.00
13.00	01300	NURSING ADMINISTRATION	5,140	0	5,140	0	14	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,044	0	1,044	0	2	14.00
15.00	01500	PHARMACY	1,441	0	1,441	0	6	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,452	78,159	11,452	33,529	34	30.00
31.00	03100	INTENSIVE CARE UNIT	3,166	36,719	3,166	10,936	11	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,827	40,106	14,827	0	9	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	4	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,171	0	13,171	0	24	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1	56.00
57.00	05700	CT SCAN	1,087	0	1,087	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,042	0	1,042	0	2	58.00
60.00	06000	LABORATORY	4,710	0	4,710	0	21	60.00
65.00	06500	RESPIRATORY THERAPY	1,251	0	1,251	0	9	65.00
66.00	06600	PHYSICAL THERAPY	3,393	0	3,393	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,231	0	1,231	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	470	0	470	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	3,719	0	3,719	0	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,248	0	2,248	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	524	0	524	0	0	90.01
91.00	09100	EMERGENCY	5,491	73,224	5,491	0	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,398	228,208	81,836	44,465	183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	932	0	932	0	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,996	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,602	0	2,602	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,485	0	0	0	5	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,701,953	154,562	844,635	771,986	191,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.972657	0.677286	9.893815	17.361655	1,010.888889	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	252,609	11,177	29,807	57,292	35,343	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.773778	0.048977	0.349151	1.288474	187.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/27/2018 10:35 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	74					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,380,613				14.00
15.00	01500	PHARMACY	0	18,039	76,015,357			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	3,389		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29	108,223	3,628	2,554		30.00
31.00	03100	INTENSIVE CARE UNIT	10	39,256	1,497	835		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3	341,445	1,359	0		50.00
51.00	05100	RECOVERY ROOM	4	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7	84,026	4,942	0		54.00
56.00	05600	RADIOISOTOPE	0	7,483	0	0		56.00
57.00	05700	CT SCAN	0	40,553	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,770	0	0		58.00
60.00	06000	LABORATORY	0	168,355	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	83,720	241	0		65.00
66.00	06600	PHYSICAL THERAPY	1	6,724	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2	47,079	165	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,970	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	107,571	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	76,000,338	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	18	142,378	3,187	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74	1,380,592	76,015,357	3,389		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	21	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,535,036	1,420,087	1,360,521	67,795		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34,257.243243	1.028592	0.017898	20.004426		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	90,385	25,007	30,868	713		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,221.418919	0.018113	0.000406	0.210387		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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,848,392		5,848,392	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,310,603		2,310,603	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,273,196		2,273,196	0	0	50.00
51.00	05100	RECOVERY ROOM	656,021		656,021	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,674		4,057,674	0	0	54.00
56.00	05600	RADIOISOTOPE	238,979		238,979	0	0	56.00
57.00	05700	CT SCAN	607,560		607,560	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	480,092		480,092	0	0	58.00
60.00	06000	LABORATORY	5,842,005		5,842,005	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,082,101	0	1,082,101	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,201,231	0	1,201,231	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	556,562	0	556,562	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	130,899	0	130,899	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,159,662		1,159,662	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	435,394		435,394	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	254,584		254,584	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,529,610		11,529,610	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	215,847		215,847	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC - DIABETES	152,523		152,523	0	0	90.01
91.00	09100	EMERGENCY	4,778,516		4,778,516	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,842,995		1,842,995		0	92.00
200.00		Subtotal (see instructions)	45,654,446	0	45,654,446	0	0	200.00
201.00		Less Observation Beds	1,842,995		1,842,995		0	201.00
202.00		Total (see instructions)	43,811,451	0	43,811,451	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,733,924		4,733,924			30.00
31.00	03100	INTENSIVE CARE UNIT	5,513,827		5,513,827			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,806,556	18,448,094	20,254,650	0.112231	0.000000	50.00
51.00	05100	RECOVERY ROOM	211,138	2,650,928	2,862,066	0.229212	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,888	21,178,459	21,716,347	0.186849	0.000000	54.00
56.00	05600	RADIOISOTOPE	163,376	1,948,825	2,112,201	0.113142	0.000000	56.00
57.00	05700	CT SCAN	388,964	5,880,895	6,269,859	0.096902	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79,252	2,431,944	2,511,196	0.191181	0.000000	58.00
60.00	06000	LABORATORY	2,712,305	18,929,504	21,641,809	0.269941	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	782,308	1,562,108	2,344,416	0.461565	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,063	2,742,311	3,011,374	0.398898	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,518	934,773	1,092,291	0.509536	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	45,860	371,209	417,069	0.313855	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	725,163	9,408,234	10,133,397	0.114440	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,530	1,849,534	2,137,064	0.203735	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,899	929,087	982,986	0.258990	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,759,181	31,803,018	36,562,199	0.315342	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,471,631	1,471,631	0.146672	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	71,667	71,667	2.128218	0.000000	90.01
91.00	09100	EMERGENCY	762,960	28,279,144	29,042,104	0.164538	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	49,522	9,874,764	9,924,286	0.185706	0.000000	92.00
200.00		Subtotal (see instructions)	24,040,234	160,766,129	184,806,363			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,040,234	160,766,129	184,806,363			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - DIABETES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,848,392		5,848,392	0	5,848,392	30.00
31.00	03100	INTENSIVE CARE UNIT	2,310,603		2,310,603	0	2,310,603	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,273,196		2,273,196	0	2,273,196	50.00
51.00	05100	RECOVERY ROOM	656,021		656,021	0	656,021	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,674		4,057,674	0	4,057,674	54.00
56.00	05600	RADIOISOTOPE	238,979		238,979	0	238,979	56.00
57.00	05700	CT SCAN	607,560		607,560	0	607,560	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	480,092		480,092	0	480,092	58.00
60.00	06000	LABORATORY	5,842,005		5,842,005	0	5,842,005	60.00
65.00	06500	RESPIRATORY THERAPY	1,082,101	0	1,082,101	0	1,082,101	65.00
66.00	06600	PHYSICAL THERAPY	1,201,231	0	1,201,231	0	1,201,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	556,562	0	556,562	0	556,562	67.00
68.00	06800	SPEECH PATHOLOGY	130,899	0	130,899	0	130,899	68.00
69.00	06900	ELECTROCARDIOLOGY	1,159,662		1,159,662	0	1,159,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	435,394		435,394	0	435,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	254,584		254,584	0	254,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,529,610		11,529,610	0	11,529,610	73.00
76.97	07697	CARDIAC REHABILITATION	215,847		215,847	0	215,847	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC - DIABETES	152,523		152,523	0	152,523	90.01
91.00	09100	EMERGENCY	4,778,516		4,778,516	0	4,778,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,842,995		1,842,995		1,842,995	92.00
200.00		Subtotal (see instructions)	45,654,446	0	45,654,446	0	45,654,446	200.00
201.00		Less Observation Beds	1,842,995		1,842,995		1,842,995	201.00
202.00		Total (see instructions)	43,811,451	0	43,811,451	0	43,811,451	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,733,924		4,733,924			30.00
31.00	03100	INTENSIVE CARE UNIT	5,513,827		5,513,827			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,806,556	18,448,094	20,254,650	0.112231	0.000000	50.00
51.00	05100	RECOVERY ROOM	211,138	2,650,928	2,862,066	0.229212	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,888	21,178,459	21,716,347	0.186849	0.000000	54.00
56.00	05600	RADIOISOTOPE	163,376	1,948,825	2,112,201	0.113142	0.000000	56.00
57.00	05700	CT SCAN	388,964	5,880,895	6,269,859	0.096902	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79,252	2,431,944	2,511,196	0.191181	0.000000	58.00
60.00	06000	LABORATORY	2,712,305	18,929,504	21,641,809	0.269941	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	782,308	1,562,108	2,344,416	0.461565	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,063	2,742,311	3,011,374	0.398898	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,518	934,773	1,092,291	0.509536	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	45,860	371,209	417,069	0.313855	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	725,163	9,408,234	10,133,397	0.114440	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,530	1,849,534	2,137,064	0.203735	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,899	929,087	982,986	0.258990	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,759,181	31,803,018	36,562,199	0.315342	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,471,631	1,471,631	0.146672	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	71,667	71,667	2.128218	0.000000	90.01
91.00	09100	EMERGENCY	762,960	28,279,144	29,042,104	0.164538	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	49,522	9,874,764	9,924,286	0.185706	0.000000	92.00
200.00		Subtotal (see instructions)	24,040,234	160,766,129	184,806,363			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,040,234	160,766,129	184,806,363			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - DIABETES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	223,803	20,254,650	0.011049	642,439	7,098	50.00
51.00	05100	RECOVERY ROOM	9,683	2,862,066	0.003383	66,526	225	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,889	21,716,347	0.010033	290,255	2,912	54.00
56.00	05600	RADIOISOTOPE	2,101	2,112,201	0.000995	68,124	68	56.00
57.00	05700	CT SCAN	20,249	6,269,859	0.003230	119,054	385	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,889	2,511,196	0.007124	48,516	346	58.00
60.00	06000	LABORATORY	112,428	21,641,809	0.005195	1,448,596	7,525	60.00
65.00	06500	RESPIRATORY THERAPY	27,517	2,344,416	0.011737	445,994	5,235	65.00
66.00	06600	PHYSICAL THERAPY	56,972	3,011,374	0.018919	153,493	2,904	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,202	1,092,291	0.019411	84,541	1,641	67.00
68.00	06800	SPEECH PATHOLOGY	7,430	417,069	0.017815	30,738	548	68.00
69.00	06900	ELECTROCARDIOLOGY	61,114	10,133,397	0.006031	442,623	2,669	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,204	2,137,064	0.002435	156,981	382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,043	982,986	0.003096	3,012	9	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,183	36,562,199	0.002959	2,435,215	7,206	73.00
76.97	07697	CARDIAC REHABILITATION	31,624	1,471,631	0.021489	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	8,101	71,667	0.113037	0	0	90.01
91.00	09100	EMERGENCY	136,040	29,042,104	0.004684	27,055	127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	86,479	9,924,286	0.008714	0	0	92.00
200.00		Total (lines 50 through 199)	1,156,951	174,558,612		6,463,162	39,280	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	20,254,650	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,862,066	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,716,347	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,112,201	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	6,269,859	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,511,196	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	21,641,809	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,344,416	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,011,374	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,092,291	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	417,069	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,133,397	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,137,064	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	982,986	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,562,199	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,471,631	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	71,667	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	29,042,104	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	9,924,286	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	174,558,612		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	642,439	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	66,526	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	290,255	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	68,124	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	119,054	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	48,516	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,448,596	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	445,994	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	153,493	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	84,541	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	30,738	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	442,623	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	156,981	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	3,012	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,435,215	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	27,055	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,463,162	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.112231	0	5,261,824	0	0	50.00
51.00	05100	RECOVERY ROOM	0.229212	0	714,556	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	0	7,309,314	0	0	54.00
56.00	05600	RADIOISOTOPE	0.113142	0	978,981	0	0	56.00
57.00	05700	CT SCAN	0.096902	0	2,325,462	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	0	814,315	0	0	58.00
60.00	06000	LABORATORY	0.269941	0	5,577,336	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	0	589,147	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	0	891,998	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	0	264,203	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	0	35,356	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	0	3,629,327	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	0	302,462	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	0	286,783	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	0	12,312,125	13,292	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	698,709	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	11,800	0	0	90.01
91.00	09100	EMERGENCY	0.164538	0	9,598,042	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	5,285,961	0	0	92.00
200.00		Subtotal (see instructions)		0	56,887,701	13,292	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	56,887,701	13,292	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	590,540	0		50.00
51.00	05100	RECOVERY ROOM	163,785	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,365,738	0		54.00
56.00	05600	RADIOISOTOPE	110,764	0		56.00
57.00	05700	CT SCAN	225,342	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	155,682	0		58.00
60.00	06000	LABORATORY	1,505,552	0		60.00
65.00	06500	RESPIRATORY THERAPY	271,930	0		65.00
66.00	06600	PHYSICAL THERAPY	355,816	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	134,621	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,097	0		68.00
69.00	06900	ELECTROCARDIOLOGY	415,340	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,622	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	74,274	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,882,530	4,192		73.00
76.97	07697	CARDIAC REHABILITATION	102,481	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	25,113	0		90.01
91.00	09100	EMERGENCY	1,579,243	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	981,635	0		92.00
200.00		Subtotal (see instructions)	12,013,105	4,192		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	12,013,105	4,192		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.112231	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.229212	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.113142	0	0	0	0	56.00
57.00	05700	CT SCAN	0.096902	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	0	0	0	0	58.00
60.00	06000	LABORATORY	0.269941	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.164538	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0		90.01
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.112231	0	94,523	0	0	50.00
51.00	05100	RECOVERY ROOM	0.229212	0	14,268	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	0	180,166	0	0	54.00
56.00	05600	RADIOISOTOPE	0.113142	0	4,515	0	0	56.00
57.00	05700	CT SCAN	0.096902	0	71,877	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	0	27,818	0	0	58.00
60.00	06000	LABORATORY	0.269941	0	142,135	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	0	23,216	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	0	34,242	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	0	14,195	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	0	38,038	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	0	80,765	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	0	8,112	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	0	4,940	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	0	244,393	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	930	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.164538	0	476,158	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	114,231	0	0	92.00
200.00		Subtotal (see instructions)		0	1,574,522	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,574,522	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	10,608	0		50.00
51.00	05100	RECOVERY ROOM	3,270	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,664	0		54.00
56.00	05600	RADIOISOTOPE	511	0		56.00
57.00	05700	CT SCAN	6,965	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,318	0		58.00
60.00	06000	LABORATORY	38,368	0		60.00
65.00	06500	RESPIRATORY THERAPY	10,716	0		65.00
66.00	06600	PHYSICAL THERAPY	13,659	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,233	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,938	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,243	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,653	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,279	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,067	0		73.00
76.97	07697	CARDIAC REHABILITATION	136	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0		90.01
91.00	09100	EMERGENCY	78,346	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,213	0		92.00
200.00		Subtotal (see instructions)	331,187	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	331,187	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/27/2018 10:35 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,245	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,878	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,554	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	318	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	49	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,559	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)	318	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,848,392	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)	7,596	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)	450,249	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,398,143	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,398,143	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)	1,391.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,170,112	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,170,112	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,310,603	835	2,767.19	518	1,433,404	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)	1,736,742	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,340,258	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	442,653	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)	442,653	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,324	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,391.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,842,995	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	274,422	5,848,392	0.046923	1,842,995	86,479	90.00
91.00	Nursing School cost	0	5,848,392	0.000000	1,842,995	0	91.00
92.00	Allied health cost	0	5,848,392	0.000000	1,842,995	0	92.00
93.00	All other Medical Education	0	5,848,392	0.000000	1,842,995	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/27/2018 10:35 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,245	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,878	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,554	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	318	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	49	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)	27	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,848,392	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)	7,596	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)	450,249	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,398,143	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,398,143	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)	1,391.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	37,584	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)	37,584	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,310,603	835	2,767.19	14	38,741	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)	44,071	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	120,396	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,324	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,391.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,842,995	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	274,422	5,848,392	0.046923	1,842,995	86,479	90.00
91.00	Nursing School cost	0	5,848,392	0.000000	1,842,995	0	91.00
92.00	Allied health cost	0	5,848,392	0.000000	1,842,995	0	92.00
93.00	All other Medical Education	0	5,848,392	0.000000	1,842,995	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,689,653		30.00
31.00	03100	INTENSIVE CARE UNIT		2,991,761		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112231	642,439	72,102	50.00
51.00	05100	RECOVERY ROOM	0.229212	66,526	15,249	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	290,255	54,234	54.00
56.00	05600	RADIOISOTOPE	0.113142	68,124	7,708	56.00
57.00	05700	CT SCAN	0.096902	119,054	11,537	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	48,516	9,275	58.00
60.00	06000	LABORATORY	0.269941	1,448,596	391,035	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	445,994	205,855	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	153,493	61,228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	84,541	43,077	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	30,738	9,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	442,623	50,654	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	156,981	31,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	3,012	780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	2,435,215	767,926	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	0	90.01
91.00	09100	EMERGENCY	0.164538	27,055	4,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,463,162	1,736,742	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)		6,463,162		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112231	13,943	1,565	50.00
51.00	05100	RECOVERY ROOM	0.229212	2,939	674	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	16,279	3,042	54.00
56.00	05600	RADIOISOTOPE	0.113142	3,064	347	56.00
57.00	05700	CT SCAN	0.096902	3,966	384	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	0	0	58.00
60.00	06000	LABORATORY	0.269941	126,791	34,226	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	47,559	21,952	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	48,718	19,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	34,617	17,639	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	3,958	1,242	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	5,750	658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	3,954	806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	300,558	94,779	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	0	90.01
91.00	09100	EMERGENCY	0.164538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		612,096	196,748	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)		612,096		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		50,847		30.00
31.00	03100	INTENSIVE CARE UNIT		77,061		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112231	20,283	2,276	50.00
51.00	05100	RECOVERY ROOM	0.229212	2,939	674	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	6,293	1,176	54.00
56.00	05600	RADIOISOTOPE	0.113142	0	0	56.00
57.00	05700	CT SCAN	0.096902	4,156	403	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	0	0	58.00
60.00	06000	LABORATORY	0.269941	25,433	6,865	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	12,968	5,986	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	470	187	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	1,013	318	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	5,546	635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	2,143	437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	65,449	20,639	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	0	90.01
91.00	09100	EMERGENCY	0.164538	27,199	4,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		173,892	44,071	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)		173,892		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112231	0	0	50.00
51.00	05100	RECOVERY ROOM	0.229212	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186849	0	0	54.00
56.00	05600	RADIOISOTOPE	0.113142	0	0	56.00
57.00	05700	CT SCAN	0.096902	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191181	0	0	58.00
60.00	06000	LABORATORY	0.269941	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.461565	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398898	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.509536	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.313855	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114440	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.203735	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315342	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.146672	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.128218	0	0	90.01
91.00	09100	EMERGENCY	0.164538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.185706	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/27/2018 10:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,017,297	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12,017,297	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	12,137,470	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	91,979	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	10,324,292	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,721,199	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,721,199	30.00
31.00	Primary payer payments	390	31.00
32.00	Subtotal (line 30 minus line 31)	1,720,809	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)	828,849	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	538,752	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	825,295	36.00
37.00	Subtotal (see instructions)	2,259,561	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,259,561	40.00
40.01	Sequestration adjustment (see instructions)	45,191	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,173,648	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-959,278	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	721,462	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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,310,670		3,173,648	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	07/07/2017	449,700		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		449,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,760,370		3,173,648	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		987,422		959,278	6.02
7.00	Total Medicare program liability (see instructions)		4,772,948		2,214,370	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		657,402		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		657,402		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,652		0	6.02
7.00	Total Medicare program liability (see instructions)		631,750		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/27/2018 10:35 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/27/2018 10:35 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	447,080	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	198,715	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	318	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	645,795	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	645,795	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	645,795	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,152	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	644,643	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	644,643	0	19.00
19.01	Sequestration adjustment (see instructions)	12,893	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	657,402	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-25,652	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	22,440	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/27/2018 10:35 am

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/27/2018 10:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,340,258	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,340,258	4.00
5.00	Primary payer payments	7,831	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,385,830	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,385,830	19.00
20.00	Deductibles (exclude professional component)	545,832	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,839,998	22.00
23.00	Coinsurance	2,632	23.00
24.00	Subtotal (line 22 minus line 23)	4,837,366	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	50,753	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	32,989	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,289	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,870,355	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	4,870,355	30.00
30.01	Sequestration adjustment (see instructions)	97,407	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,760,370	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-987,422	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	184,177	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/27/2018 10:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	38,462,760	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,758,116	0	0	0	4.00
5.00	Other receivable	-6,613,043	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,046,181	0	0	0	7.00
8.00	Prepaid expenses	212,561	0	0	0	8.00
9.00	Other current assets	-22,656	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)	41,843,919	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	931,334	0	0	0	12.00
13.00	Land improvements	1,119,735	0	0	0	13.00
14.00	Accumulated depreciation	-996,966	0	0	0	14.00
15.00	Buildings	20,052,249	0	0	0	15.00
16.00	Accumulated depreciation	-12,516,091	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	200,961	0	0	0	21.00
22.00	Accumulated depreciation	-172,264	0	0	0	22.00
23.00	Major movable equipment	19,257,241	0	0	0	23.00
24.00	Accumulated depreciation	-16,025,900	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	828,191	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,678,490	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	4,044,167	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,044,167	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,566,576	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,250,651	0	0	0	37.00
38.00	Salaries, wages, and fees payable	588,884	0	0	0	38.00
39.00	Payroll taxes payable	888,235	0	0	0	39.00
40.00	Notes and loans payable (short term)	66,727	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,148,856	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,943,353	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	204,815	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	204,815	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,148,168	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	50,418,408				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)	50,418,408	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,566,576	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/27/2018 10:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		49,448,173		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,333,297				2.00
3.00	Total (sum of line 1 and line 2)		56,781,470		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)		56,781,470		0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	6,362,250		0		0	12.00
13.00	RESTRICTED FUND BALANCE	812		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)		6,363,062		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		50,418,408		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	INTERCOMPANY CAPITAL TRANSFER		0		12.00
13.00	RESTRICTED FUND BALANCE		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: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/27/2018 10:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,733,925		4,733,925	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)	4,733,925		4,733,925	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,513,827		5,513,827	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)	5,513,827		5,513,827	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,247,752		10,247,752	17.00
18.00	Ancillary services	13,742,961	150,891,365	164,634,326	18.00
19.00	Outpatient services	49,522	9,874,764	9,924,286	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 REVENUE	0	1,538,771	1,538,771	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,040,235	162,304,900	186,345,135	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,240,945		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)		51,240,945		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/27/2018 10:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	186,345,135	1.00
2.00	Less contractual allowances and discounts on patients' accounts	129,305,643	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,039,492	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,240,945	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,798,547	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,534,750	24.00
25.00	Total other income (sum of lines 6-24)	1,534,750	25.00
26.00	Total (line 5 plus line 25)	7,333,297	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)	7,333,297	29.00