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: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 9:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 9:15 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) 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	-27,909	19,343	0	-141,010	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-12,159	0		-40,605	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-40,068	19,343	0	-181,615	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	TODD AIKENS REHAB CENTER	15T001	26900	5	01/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	N	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)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	120	914	0	0	307	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	102	0	0	46		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 3:43 pm

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

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		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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

		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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			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)	N		0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	742,403	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2018 3:43 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/10/2018	Y	04/10/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 3:43 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	AUSTIN	FISHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3172757438	AFISHER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 3:43 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR ACCOUNTANT		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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		83	30,295	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	11	4,015		0	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	101.00				0	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)		94				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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,366	27	5,528			1.00
2.00	HMO and other (see instructions)	686	1,221				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	148				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,366	27	5,528			7.00
8.00	INTENSIVE CARE UNIT	455	0	729			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		55	671			13.00
14.00	Total (see instructions)	2,821	82	6,928	0.00	510.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	553	0	1,378	0.00	8.58	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	2,611	76	4,931	0.00	8.61	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	527.77	27.00
28.00	Observation Bed Days		0	880			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	38	72			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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	750	27	1,992	1.00
2.00	HMO and other (see instructions)			169	857		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				10		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	750	27	1,992	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	40	0	93	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2018 3:43 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	39,617,520	-134,711	39,482,809	1,224,990.00	32.23	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		110,004	0	110,004	1,575.00	69.84	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,163,318	0	1,163,318	12,267.00	94.83	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		674,425	0	674,425	24,366.00	27.68	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		13,238,842	-155,288	13,083,554	263,095.00	49.73	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		47,763	0	47,763	1,987.00	24.04	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,378,916	0	1,378,916	13,388.00	103.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,488,739	0	6,488,739			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,316,276	0	2,316,276			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		16,924	0	16,924			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		141,238	0	141,238			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,288,673	120,461	3,409,134	157,526.00	21.64	26.00
27.00	Administrative & General	5.00	1,469,800	-72,368	1,397,432	62,210.00	22.46	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2018 3:43 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		285,736	0	285,736	2,800.00	102.05	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	629,953	0	629,953	28,824.00	21.86	30.00
31.00	Laundry & Linen Service	8.00	99,953	0	99,953	7,120.00	14.04	31.00
32.00	Housekeeping	9.00	711,551	0	711,551	52,827.00	13.47	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	818,552	-488,289	330,263	23,323.00	14.16	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	488,289	488,289	26,516.00	18.41	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,558,085	-3,461	1,554,624	27,101.00	57.36	38.00
39.00	Central Services and Supply	14.00	79,668	0	79,668	4,123.00	19.32	39.00
40.00	Pharmacy	15.00	475,658	0	475,658	13,213.00	36.00	40.00
41.00	Medical Records & Medical Records Library	16.00	621,668	0	621,668	30,876.00	20.13	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2018 3:43 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,065,513	-134,711	37,930,802	1,191,157.00	31.84	1.00
2.00	Excluded area salaries (see instructions)		13,238,842	-155,288	13,083,554	263,095.00	49.73	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,826,671	20,577	24,847,248	928,062.00	26.77	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,426,679	0	1,426,679	15,375.00	92.79	4.00
5.00	Subtotal wage-related costs (see inst.)		6,505,663	0	6,505,663	0.00	26.18	5.00
6.00	Total (sum of lines 3 thru 5)		32,759,013	20,577	32,779,590	943,437.00	34.74	6.00
7.00	Total overhead cost (see instructions)		10,039,297	44,632	10,083,929	436,459.00	23.10	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2018 3:43 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	879,809	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	4,897,584	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,663	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	196,217	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	227,973	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,660,123	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	21,035	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	10,313	22.00
23.00	Tuition Reimbursement	33,460	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,963,177	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/25/2018 3:43 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	47,763	8,963,177	1.00
2.00	Hospital	47,763	8,963,177	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0001 | Component CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/25/2018 3:43 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	118.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.93	0.00	1.93	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.52	0.00	1.52	5.00
6.00	Direct Nursing Service			3.84	0.00	3.84	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.08	0.00	2.08	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.01	0.00	1.01	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			18020			20.00
20.01				26900			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,034	59	8	3	1,104	21.00
22.00	Skilled Nursing Visit Charges	248,160	14,160	1,920	720	264,960	22.00
23.00	Physical Therapy Visits	849	41	3	6	899	23.00
24.00	Physical Therapy Visit Charges	220,740	10,660	780	1,560	233,740	24.00
25.00	Occupational Therapy Visits	517	39	1	2	559	25.00
26.00	Occupational Therapy Visit Charges	134,420	10,140	260	520	145,340	26.00
27.00	Speech Pathology Visits	19	28	0	0	47	27.00
28.00	Speech Pathology Visit Charges	4,940	7,280	0	0	12,220	28.00
29.00	Medical Social Service Visits	2	0	0	0	2	29.00
30.00	Medical Social Service Visit Charges	560	0	0	0	560	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,421	167	12	11	2,611	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	608,820	42,240	2,960	2,800	656,820	35.00
36.00	Total Number of Episodes (standard/non outlier)	125		4	2	131	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	457	0	0	0	457	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/25/2018 3:43 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.268860	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,748,461	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		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	19,801,846	6.00
7.00	Medicaid cost (line 1 times line 6)	5,323,924	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,575,463	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,575,463	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)	3,834,949	0	3,834,949	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,031,064	0	1,031,064	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,031,064	0	1,031,064	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	10,373,460	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	138,015	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	212,331	27.01
28.00	Non-Medicare bad debt expense (see instructions)	10,161,129	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,806,237	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,837,301	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,412,764	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,947,418	1,947,418	0	1,947,418	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,189,152	3,189,152	0	3,189,152	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	330,534	7,767,074	8,097,608	213,240	8,310,848	4.00
4.01	00401	COMMUNICATIONS	131,632	249,211	380,843	0	380,843	4.01
4.02	00402	DATA PROCESSING	711,477	759,463	1,470,940	0	1,470,940	4.02
4.03	00403	MATERIALS MANAGEMENT	306,775	51,224	357,999	0	357,999	4.03
4.04	00404	ADMITTING	710,659	14,466	725,125	0	725,125	4.04
4.05	00405	PATIENT ACCOUNTING	1,097,596	663,420	1,761,016	0	1,761,016	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,469,800	5,049,541	6,519,341	-60,030	6,459,311	5.00
7.00	00700	OPERATION OF PLANT	629,953	1,960,128	2,590,081	0	2,590,081	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,953	77,830	177,783	0	177,783	8.00
9.00	00900	HOUSEKEEPING	711,551	109,348	820,899	0	820,899	9.00
10.00	01000	DIETARY	818,552	350,144	1,168,696	-697,160	471,536	10.00
11.00	01100	CAFETERIA	0	0	0	697,160	697,160	11.00
13.00	01300	NURSING ADMINISTRATION	1,558,085	190,556	1,748,641	0	1,748,641	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,668	136,999	216,667	0	216,667	14.00
15.00	01500	PHARMACY	475,658	4,014,097	4,489,755	0	4,489,755	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621,668	213,930	835,598	0	835,598	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,293,429	758,644	5,052,073	-175,603	4,876,470	30.00
31.00	03100	INTENSIVE CARE UNIT	1,193,087	73,624	1,266,711	0	1,266,711	31.00
41.00	04100	SUBPROVIDER - IRF	734,263	138,897	873,160	-108,130	765,030	41.00
43.00	04300	NURSERY	0	0	0	175,603	175,603	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,782,710	345,198	2,127,908	0	2,127,908	50.00
53.00	05300	ANESTHESIOLOGY	0	26,046	26,046	0	26,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,068,458	733,393	2,801,851	0	2,801,851	54.00
60.00	06000	LABORATORY	1,630,801	2,123,548	3,754,349	0	3,754,349	60.00
65.00	06500	RESPIRATORY THERAPY	939,606	153,455	1,093,061	0	1,093,061	65.00
66.00	06600	PHYSICAL THERAPY	794,578	73,662	868,240	108,130	976,370	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,623	2	249,625	0	249,625	67.00
68.00	06800	SPEECH PATHOLOGY	140,072	24,418	164,490	0	164,490	68.00
69.00	06900	ELECTROCARDIOLOGY	479,947	1,352,607	1,832,554	0	1,832,554	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,165	7,243	56,408	0	56,408	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,517,772	3,517,772	-872,631	2,645,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	872,631	872,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	240,419	148,781	389,200	0	389,200	76.00
76.97	07697	CARDIAC REHABILITATION	123,432	81,011	204,443	0	204,443	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	749,603	1,957,922	2,707,525	0	2,707,525	90.00
91.00	09100	EMERGENCY	1,890,187	212,252	2,102,439	0	2,102,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	674,425	166,993	841,418	0	841,418	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		10,002	10,002	0	10,002	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,787,366	38,649,471	66,436,837	153,210	66,590,047	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	90,132	30,791	120,923	0	120,923	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,147,632	3,861,878	15,009,510	0	15,009,510	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	84,824	13,027	97,851	0	97,851	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	450,019	122,342	572,361	-153,210	419,151	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	1,046,990	1,046,990	0	1,046,990	193.03
194.00	07950	PARTNERSHIP HFC	9,452	11,911	21,363	0	21,363	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,095	0	48,095	0	48,095	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	39,617,520	43,736,410	83,353,930	0	83,353,930	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 3:43 pm

		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	83,386	2,030,804		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	0		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,189,152		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-145,746	8,165,102		4.00
4.01	00401	COMMUNICATIONS	-22,032	358,811		4.01
4.02	00402	DATA PROCESSING	0	1,470,940		4.02
4.03	00403	MATERIALS MANAGEMENT	0	357,999		4.03
4.04	00404	ADMITTING	0	725,125		4.04
4.05	00405	PATIENT ACCOUNTING	-8,224	1,752,792		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-3,517,374	2,941,937		5.00
7.00	00700	OPERATION OF PLANT	-40,836	2,549,245		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	177,783		8.00
9.00	00900	HOUSEKEEPING	0	820,899		9.00
10.00	01000	DIETARY	0	471,536		10.00
11.00	01100	CAFETERIA	-294,703	402,457		11.00
13.00	01300	NURSING ADMINISTRATION	234	1,748,875		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	216,667		14.00
15.00	01500	PHARMACY	-860	4,488,895		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,451	811,147		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,567,082	3,309,388		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,266,711		31.00
41.00	04100	SUBPROVIDER - IRF	0	765,030		41.00
43.00	04300	NURSERY	0	175,603		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,127,908		50.00
53.00	05300	ANESTHESIOLOGY	0	26,046		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,900	2,796,951		54.00
60.00	06000	LABORATORY	-70	3,754,279		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,093,061		65.00
66.00	06600	PHYSICAL THERAPY	0	976,370		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	249,625		67.00
68.00	06800	SPEECH PATHOLOGY	0	164,490		68.00
69.00	06900	ELECTROCARDIOLOGY	-398	1,832,156		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	56,408		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,645,141		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	872,631		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	-125,500	263,700		76.00
76.97	07697	CARDIAC REHABILITATION	-32,000	172,443		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-950,263	1,757,262		90.00
91.00	09100	EMERGENCY	-43,495	2,058,944		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	841,418		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-10,002	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,704,316	59,885,731		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	120,923		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,009,510		192.00
192.01	19201	SOUTH CLINIC	0	0		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	97,851		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	419,151		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	1,046,990		193.03
194.00	07950	PARTNERSHIP HFC	0	21,363		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	48,095		194.03
194.04	07954	ATHLETIC TRAINERS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,704,316	76,649,614		200.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 3:43 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY RECLASS					
1.00	NURSERY	43.00	149,719	25,884		1.00
	TOTALS		149,719	25,884		
	B - IMPLANTABLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00		872,631		1.00
	TOTALS		0	872,631		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	488,289	208,871		1.00
	TOTALS		488,289	208,871		
	D - DAY CARE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	120,461	32,749		1.00
	TOTALS		120,461	32,749		
	G - STD RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00		12,338		1.00
2.00	NURSING ADMINISTRATION	13.00		3,461		2.00
3.00	SUBPROVIDER - IRF	41.00		6,365		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		14,405		4.00
5.00	RESPIRATORY THERAPY	65.00		9,650		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00		28,462		6.00
	TOTALS		0	74,681		
	H - EMPLOYEE WELLNESS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		60,030		1.00
	TOTALS		0	60,030		
	J - PART A RECLASS					
1.00	PHYSICAL THERAPY	66.00	0	108,130		1.00
	TOTALS		0	108,130		
500.00	Grand Total: Increases		758,469	1,382,976		500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 3:43 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	149,719	25,884	0		1.00
	TOTALS		149,719	25,884			
	B - IMPLANTABLE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		872,631	0		1.00
	TOTALS		0	872,631			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	488,289	208,871	0		1.00
	TOTALS		488,289	208,871			
	D - DAY CARE RECLASS						
1.00	ADULT/CHILD CARE	193.01	120,461	32,749	0		1.00
	TOTALS		120,461	32,749			
	G - STD RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	12,338	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	3,461	0	0		2.00
3.00	SUBPROVIDER - IRF	41.00	6,365	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	14,405	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	9,650	0	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	28,462	0	0		6.00
	TOTALS		74,681	0			
	H - EMPLOYEE WELLNESS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	60,030	0	0		1.00
	TOTALS		60,030	0			
	J - PART A RECLASS						
1.00	SUBPROVIDER - IRF	41.00	0	108,130	0		1.00
	TOTALS		0	108,130			
500.00	Grand Total: Decreases		893,180	1,248,265			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

		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	4,743,329	97	0	97	0	1.00
2.00	Land Improvements	2,746,206	60,860	0	60,860	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	68,972,645	3,492,113	0	3,492,113	0	4.00
5.00	Fixed Equipment	12,930,439	77,166	0	77,166	0	5.00
6.00	Movable Equipment	50,480,013	11,071,990	0	11,071,990	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,872,632	14,702,226	0	14,702,226	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	139,872,632	14,702,226	0	14,702,226	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,743,426	0	1.00
2.00	Land Improvements	2,807,066	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	72,464,758	0	4.00
5.00	Fixed Equipment	13,007,605	0	5.00
6.00	Movable Equipment	61,552,003	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	154,574,858	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	154,574,858	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2018 3:43 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,947,418	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3,189,152	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,136,570	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	1,947,418	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,189,152	2.00
3.00	Total (sum of lines 1-2)	0	5,136,570	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2018 3:43 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	80,015,250	0	80,015,250	0.517647	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	13,007,605	0	13,007,605	0.084151	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	61,552,003	0	61,552,003	0.398202	0	2.00
3.00	Total (sum of lines 1-2)	154,574,858	0	154,574,858	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,030,804	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,189,152	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,219,956	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,030,804	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,189,152	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	5,219,956	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 3:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-2,432,229			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	0			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
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - TOWER		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 3:43 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	JMH PAIN CARE CENTER REVENUE OPERATI	B	-142,740	CLINIC	90.00	0	33.00
33.01	CAFETERIA CANTEEN VENDING REVENUE	B	-290,203	CAFETERIA	11.00	0	33.01
33.02	CAFETERIA CANTEEN VENDING REVENUE	B	-4,500	CAFETERIA	11.00	0	33.02
33.03	MISC OTHER REVENUE	B	234	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISC OTHER REVENUE	B	-860	PHARMACY	15.00	0	33.04
33.05	MISC OTHER REVENUE	B	-24,451	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	MISC OTHER REVENUE	B	-8,224	PATIENT ACCOUNTING	4.05	0	33.06
33.07	MISC OTHER REVENUE	B	-39,105	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISC OTHER REVENUE	B	237	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISC OTHER REVENUE	B	-4,130	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISC OTHER REVENUE	B	-8,981	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISC OTHER REVENUE	B	-4	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	MISC OTHER REVENUE	B	-1,138	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MISC OTHER REVENUE	B	-4,900	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	MISC OTHER REVENUE	B	-142,740	CLINIC	90.00	0	33.15
33.17	CABLE SERVICES	A	-28,419	OPERATION OF PLANT	7.00	0	33.17
33.18	TELEPHONE SERVICES	A	-1,177	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19	TELEPHONE SERVICES	A	-18,224	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	COMMUNICATIONS	A	-22,032	COMMUNICATIONS	4.01	0	33.20
33.21	ADVERTISING EXP - A&G	A	-296,448	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.23	ADVERTISING EXP - LABORATORY	A	-70	LABORATORY	60.00	0	33.23
33.24	ADVERTISING EXP - WOUND CARE	A	-1,029	CLINIC	90.00	0	33.24
33.25	DAYCARE	B	-153,210	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	DAYCARE DISCOUNT	A	10,313	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	LOBBYING EXPENSE - AHA	A	-5,275	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	LOBBYING EXPENSE - IHHA	A	-1,592	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	PROF - BUILDING	A	-12,417	OPERATION OF PLANT	7.00	0	33.29
33.30	PROF - BUILDING	A	-2,849	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31	INTEREST INCOME	B	-10,002	INTEREST EXPENSE	113.00	0	33.31
33.32	1933 AHA LIFE	A	84,563	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.32
33.33	HAF EXPENSE	A	-3,094,842	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	MISC OTHER REVENUE	B	-47,872	ADMINISTRATIVE & GENERAL	5.00	0	33.34
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,704,316				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2018 3:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,567,082	1,567,082	0	0	0	1.00
2.00	60.00	LABORATORY	110,004	0	110,004	211,500	1,575	2.00
3.00	69.00	ELECTROCARDIOLOGY	398	398	0	0	0	3.00
4.00	76.00	ONCOLOGY	125,500	125,500	0	0	0	4.00
5.00	91.00	EMERGENCY	43,495	43,495	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	32,000	32,000	0	0	0	6.00
7.00	90.00	CLINIC	663,754	663,754	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			2,542,233	2,432,229	110,004		1,575	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	160,150	8,008	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	76.00	ONCOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	90.00	CLINIC	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			160,150	8,008	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,567,082		1.00
2.00	60.00	LABORATORY	0	160,150	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	398		3.00
4.00	76.00	ONCOLOGY	0	0	0	125,500		4.00
5.00	91.00	EMERGENCY	0	0	0	43,495		5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	32,000		6.00
7.00	90.00	CLINIC	0	0	0	663,754		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	160,150	0	2,432,229		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,030,804	2,030,804				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,189,152			3,189,152		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,165,102	21,907	0	1,420	8,188,429	4.00
4.01	00401	COMMUNICATIONS	358,811	2,885	0	0	27,615	4.01
4.02	00402	DATA PROCESSING	1,470,940	45,958	0	1,495,107	149,260	4.02
4.03	00403	MATERIALS MANAGEMENT	357,999	28,089	0	7,083	64,358	4.03
4.04	00404	ADMITTING	725,125	16,438	0	0	149,088	4.04
4.05	00405	PATIENT ACCOUNTING	1,752,792	48,822	0	12,502	230,264	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	2,941,937	69,936	0	31,379	293,166	5.00
7.00	00700	OPERATION OF PLANT	2,549,245	183,246	0	48,131	132,157	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	177,783	17,649	0	5,300	20,969	8.00
9.00	00900	HOUSEKEEPING	820,899	13,707	0	4,769	149,276	9.00
10.00	01000	DIETARY	471,536	28,757	0	22,196	69,286	10.00
11.00	01100	CAFETERIA	402,457	30,622	0	0	102,438	11.00
13.00	01300	NURSING ADMINISTRATION	1,748,875	72,440	0	34,987	326,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	216,667	12,473	0	35,289	16,713	14.00
15.00	01500	PHARMACY	4,488,895	15,021	0	5,965	99,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	811,147	28,478	0	8,618	130,419	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,309,388	202,459	0	139,331	869,305	30.00
31.00	03100	INTENSIVE CARE UNIT	1,266,711	57,896	0	38,066	250,297	31.00
41.00	04100	SUBPROVIDER - IRF	765,030	49,651	0	20,977	152,705	41.00
43.00	04300	NURSERY	175,603	4,589	0	0	31,409	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,127,908	335,959	0	476,667	373,993	50.00
53.00	05300	ANESTHESIOLOGY	26,046	2,893	0	15,178	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,796,951	121,371	0	367,316	430,918	54.00
60.00	06000	LABORATORY	3,754,279	59,093	0	151,019	342,124	60.00
65.00	06500	RESPIRATORY THERAPY	1,093,061	2,746	0	16,558	195,095	65.00
66.00	06600	PHYSICAL THERAPY	976,370	46,531	0	10,800	166,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,625	9,801	0	2,552	52,368	67.00
68.00	06800	SPEECH PATHOLOGY	164,490	609	0	400	29,386	68.00
69.00	06900	ELECTROCARDIOLOGY	1,832,156	7,929	0	36,298	100,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,408	1,336	0	1,978	10,314	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,645,141	0	0	15,004	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	872,631	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	263,700	51,384	0	2,313	50,437	76.00
76.97	07697	CARDIAC REHABILITATION	172,443	18,435	0	11,046	25,895	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,757,262	84,546	0	17,664	157,258	90.00
91.00	09100	EMERGENCY	2,058,944	72,931	0	33,254	396,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	841,418	9,581	0	69	141,487	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,885,731	1,776,168	0	3,069,236	5,737,853	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	120,923	9,522	0	4,772	18,909	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,009,510	190,331	0	114,563	2,332,661	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	97,851	2,951	0	581	17,795	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	419,151	35,475	0	0	69,138	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	1,046,990	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	21,363	16,357	0	0	1,983	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,095	0	0	0	10,090	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	76,649,614	2,030,804	0	3,189,152	8,188,429	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	389,311					4.01
4.02	00402	DATA PROCESSING	38,730	3,199,995				4.02
4.03	00403	MATERIALS MANAGEMENT	8,320	84,068	549,917			4.03
4.04	00404	ADMITTING	9,754	79,441	1,973	981,819		4.04
4.05	00405	PATIENT ACCOUNTING	25,246	353,241	4,054	0	2,426,921	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	22,091	374,840	11,439	0	0	5.00
7.00	00700	OPERATION OF PLANT	14,058	27,766	556	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,434	18,510	2,428	0	0	8.00
9.00	00900	HOUSEKEEPING	4,016	0	13,993	0	0	9.00
10.00	01000	DIETARY	7,459	99,494	37,979	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,197	51,675	7,407	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,571	0	0	14.00
15.00	01500	PHARMACY	6,598	20,053	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,615	135,743	360	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,124	230,609	33,043	62,067	153,429	30.00
31.00	03100	INTENSIVE CARE UNIT	8,033	77,898	9,618	6,647	16,431	31.00
41.00	04100	SUBPROVIDER - IRF	5,164	14,654	2,526	8,350	20,642	41.00
43.00	04300	NURSERY	0	0	0	2,627	6,494	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,246	313,906	22,472	142,215	351,556	50.00
53.00	05300	ANESTHESIOLOGY	0	0	402	19,627	48,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,918	129,573	29,611	178,945	442,213	54.00
60.00	06000	LABORATORY	19,509	144,227	181,805	136,351	337,062	60.00
65.00	06500	RESPIRATORY THERAPY	5,164	107,206	15,314	26,307	65,031	65.00
66.00	06600	PHYSICAL THERAPY	7,172	52,446	3,044	17,449	43,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,721	13,883	0	9,289	22,962	67.00
68.00	06800	SPEECH PATHOLOGY	1,721	13,112	3	3,139	7,760	68.00
69.00	06900	ELECTROCARDIOLOGY	12,336	167,365	9,888	19,376	47,897	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	574	6,170	183	631	1,560	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20,725	48,565	120,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,019	29,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,154	141,285	73.00
76.00	03020	ONCOLOGY	10,615	40,877	1,652	3,612	8,929	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,147	2,809	6,944	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,025	36,250	18,963	49,539	122,461	90.00
91.00	09100	EMERGENCY	16,927	130,344	13,975	118,275	292,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,598	60,159	2,134	6,138	15,173	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	333,365	2,783,510	455,265	931,131	2,301,619	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,303	37,792	2,224	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,053	322,390	80,976	50,309	124,365	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	861	13,112	6	379	937	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	1,434	30,079	9,480	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	1,873	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,295	13,112	93	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	389,311	3,199,995	549,917	981,819	2,426,921	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	3,744,788	3,744,788				5.00
7.00	00700	OPERATION OF PLANT	2,955,159	151,792	3,106,951			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	244,073	12,537	33,985	290,595		8.00
9.00	00900	HOUSEKEEPING	1,006,660	51,707	26,393	55,086	1,139,846	9.00
10.00	01000	DIETARY	736,707	37,841	55,374	5,993	20,718	10.00
11.00	01100	CAFETERIA	535,517	27,507	58,964	0	22,061	11.00
13.00	01300	NURSING ADMINISTRATION	2,254,724	115,814	139,488	0	52,188	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	289,713	14,881	24,018	0	8,986	14.00
15.00	01500	PHARMACY	4,636,320	238,145	28,924	0	10,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,125,380	57,805	54,837	0	20,517	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,029,755	258,353	389,850	72,105	145,859	30.00
31.00	03100	INTENSIVE CARE UNIT	1,731,597	88,943	111,483	16,390	41,710	31.00
41.00	04100	SUBPROVIDER - IRF	1,039,699	53,404	95,607	12,509	35,770	41.00
43.00	04300	NURSERY	220,722	11,337	8,835	0	3,306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,169,922	214,188	646,912	51,689	242,035	50.00
53.00	05300	ANESTHESIOLOGY	112,663	5,787	5,570	0	2,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,511,816	231,749	233,709	23,793	87,440	54.00
60.00	06000	LABORATORY	5,125,469	263,270	113,787	0	42,572	60.00
65.00	06500	RESPIRATORY THERAPY	1,526,482	78,408	5,287	0	1,978	65.00
66.00	06600	PHYSICAL THERAPY	1,323,640	67,989	89,599	1,681	33,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,201	18,604	18,873	0	7,061	67.00
68.00	06800	SPEECH PATHOLOGY	220,620	11,332	1,173	0	439	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,933	114,746	15,268	2,233	5,712	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,154	4,066	2,573	0	963	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,849,488	146,364	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	914,360	46,966	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	198,439	10,193	0	0	0	73.00
76.00	03020	ONCOLOGY	433,519	22,268	98,943	0	37,019	76.00
76.97	07697	CARDIAC REHABILITATION	238,719	12,262	35,497	0	13,281	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,249,968	115,570	162,799	1,700	60,910	90.00
91.00	09100	EMERGENCY	3,133,566	160,956	140,435	43,180	52,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,082,757	55,616	18,448	0	6,902	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,317,530	2,700,400	2,616,631	286,359	956,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	198,445	10,193	18,335	0	6,860	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,272,158	938,579	366,496	4,236	137,121	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	134,473	6,907	5,683	0	2,126	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	564,757	29,009	68,309	0	25,557	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	1,048,863	53,875	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	55,203	2,836	31,497	0	11,784	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	58,185	2,989	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	76,649,614	3,744,788	3,106,951	290,595	1,139,846	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	856,633					10.00
11.00	01100	CAFETERIA	0	644,049				11.00
13.00	01300	NURSING ADMINISTRATION	0	19,890	2,582,104			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,124	37,158	377,880		14.00
15.00	01500	PHARMACY	0	11,291	0	0	4,925,502	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,244	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	585,482	81,723	971,962	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	113,823	26,083	310,220	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	157,328	14,909	177,321	0	0	41.00
43.00	04300	NURSERY	0	3,331	39,622	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,589	530,314	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,559	0	0	0	54.00
60.00	06000	LABORATORY	0	53,962	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,928	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,567	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,012	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,810	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,429	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,292	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	377,880	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	4,925,502	73.00
76.00	03020	ONCOLOGY	0	5,875	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,012	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24,953	0	0	0	90.00
91.00	09100	EMERGENCY	0	43,344	515,507	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	14,972	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	856,633	484,899	2,582,104	377,880	4,925,502	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,517	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	113,444	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	1,809	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	25,845	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	49	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	13,486	0	0	0	194.04
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)	856,633	644,049	2,582,104	377,880	4,925,502	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,283,783					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,156	7,616,245	0	7,616,245		30.00
31.00	03100	INTENSIVE CARE UNIT	8,691	2,448,940	0	2,448,940		31.00
41.00	04100	SUBPROVIDER - IRF	10,919	1,597,466	0	1,597,466		41.00
43.00	04300	NURSERY	3,435	290,588	0	290,588		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	185,954	6,085,603	0	6,085,603		50.00
53.00	05300	ANESTHESIOLOGY	25,663	151,767	0	151,767		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,980	5,371,046	0	5,371,046		54.00
60.00	06000	LABORATORY	178,287	5,777,347	0	5,777,347		60.00
65.00	06500	RESPIRATORY THERAPY	34,398	1,667,481	0	1,667,481		65.00
66.00	06600	PHYSICAL THERAPY	22,815	1,558,814	0	1,558,814		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,146	423,897	0	423,897		67.00
68.00	06800	SPEECH PATHOLOGY	4,105	240,479	0	240,479		68.00
69.00	06900	ELECTROCARDIOLOGY	25,335	2,407,656	0	2,407,656		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	825	88,873	0	88,873		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,502	3,437,234	0	3,437,234		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,715	977,041	0	977,041		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,732	5,208,866	0	5,208,866		73.00
76.00	03020	ONCOLOGY	4,723	602,347	0	602,347		76.00
76.97	07697	CARDIAC REHABILITATION	3,673	306,444	0	306,444		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	64,775	2,680,675	0	2,680,675		90.00
91.00	09100	EMERGENCY	154,651	4,244,181	0	4,244,181		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,025	1,186,720	0	1,186,720		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,217,505	54,369,710	0	54,369,710		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	238,350	0	238,350		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,782	19,897,816	0	19,897,816		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	496	151,494	0	151,494		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	713,477	0	713,477		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	1,102,738	0	1,102,738		193.03
194.00	07950	PARTNERSHIP HFC	0	101,369	0	101,369		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	61,174	0	61,174		194.03
194.04	07954	ATHLETIC TRAINERS	0	13,486	0	13,486		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,283,783	76,649,614	0	76,649,614		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS BLDG & FIXT - TOWER	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	21,907	0	1,420	23,327	4.00
4.01	00401	COMMUNICATIONS	0	2,885	0	0	2,885	4.01
4.02	00402	DATA PROCESSING	0	45,958	0	1,495,107	1,541,065	4.02
4.03	00403	MATERIALS MANAGEMENT	0	28,089	0	7,083	35,172	4.03
4.04	00404	ADMITTING	0	16,438	0	0	16,438	4.04
4.05	00405	PATIENT ACCOUNTING	0	48,822	0	12,502	61,324	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	69,936	0	31,379	101,315	5.00
7.00	00700	OPERATION OF PLANT	0	183,246	0	48,131	231,377	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,649	0	5,300	22,949	8.00
9.00	00900	HOUSEKEEPING	0	13,707	0	4,769	18,476	9.00
10.00	01000	DIETARY	0	28,757	0	22,196	50,953	10.00
11.00	01100	CAFETERIA	0	30,622	0	0	30,622	11.00
13.00	01300	NURSING ADMINISTRATION	0	72,440	0	34,987	107,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,473	0	35,289	47,762	14.00
15.00	01500	PHARMACY	0	15,021	0	5,965	20,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,478	0	8,618	37,096	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	202,459	0	139,331	341,790	30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,896	0	38,066	95,962	31.00
41.00	04100	SUBPROVIDER - IRF	0	49,651	0	20,977	70,628	41.00
43.00	04300	NURSERY	0	4,589	0	0	4,589	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	335,959	0	476,667	812,626	50.00
53.00	05300	ANESTHESIOLOGY	0	2,893	0	15,178	18,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,371	0	367,316	488,687	54.00
60.00	06000	LABORATORY	0	59,093	0	151,019	210,112	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,746	0	16,558	19,304	65.00
66.00	06600	PHYSICAL THERAPY	0	46,531	0	10,800	57,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,801	0	2,552	12,353	67.00
68.00	06800	SPEECH PATHOLOGY	0	609	0	400	1,009	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,929	0	36,298	44,227	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,336	0	1,978	3,314	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,004	15,004	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
76.00	03020	ONCOLOGY	0	51,384	0	2,313	53,697	76.00
76.97	07697	CARDIAC REHABILITATION	0	18,435	0	11,046	29,481	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	84,546	0	17,664	102,210	90.00
91.00	09100	EMERGENCY	0	72,931	0	33,254	106,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,581	0	69	9,650	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,776,168	0	3,069,236	4,845,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,522	0	4,772	14,294	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	190,331	0	114,563	304,894	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	2,951	0	581	3,532	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	35,475	0	0	35,475	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	16,357	0	0	16,357	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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	2,030,804	0	3,189,152	5,219,956	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	
			4.00	4.01	4.02	4.03	4.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,327					4.00
4.01	00401	COMMUNICATIONS	79	2,964				4.01
4.02	00402	DATA PROCESSING	425	295	1,541,785			4.02
4.03	00403	MATERIALS MANAGEMENT	183	63	40,505	75,923		4.03
4.04	00404	ADMITTING	425	74	38,275	272	55,484	4.04
4.05	00405	PATIENT ACCOUNTING	656	192	170,195	560	0	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	836	168	180,601	1,579	0	5.00
7.00	00700	OPERATION OF PLANT	377	107	13,378	77	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60	11	8,918	335	0	8.00
9.00	00900	HOUSEKEEPING	426	31	0	1,932	0	9.00
10.00	01000	DIETARY	197	57	47,937	5,244	0	10.00
11.00	01100	CAFETERIA	292	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	930	100	24,897	1,023	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48	0	0	1,183	0	14.00
15.00	01500	PHARMACY	284	50	9,662	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	372	81	65,402	50	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,478	229	111,110	4,562	3,501	30.00
31.00	03100	INTENSIVE CARE UNIT	713	61	37,532	1,328	375	31.00
41.00	04100	SUBPROVIDER - IRF	435	39	7,060	349	471	41.00
43.00	04300	NURSERY	90	0	0	0	148	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,066	192	151,243	3,103	8,023	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	56	1,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,228	114	62,429	4,088	10,193	54.00
60.00	06000	LABORATORY	975	149	69,490	25,100	7,692	60.00
65.00	06500	RESPIRATORY THERAPY	556	39	51,653	2,114	1,484	65.00
66.00	06600	PHYSICAL THERAPY	475	55	25,269	420	984	66.00
67.00	06700	OCCUPATIONAL THERAPY	149	13	6,689	0	524	67.00
68.00	06800	SPEECH PATHOLOGY	84	13	6,317	0	177	68.00
69.00	06900	ELECTROCARDIOLOGY	287	94	80,638	1,365	1,093	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29	4	2,973	25	36	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,861	2,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	678	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,224	73.00
76.00	03020	ONCOLOGY	144	81	19,695	228	204	76.00
76.97	07697	CARDIAC REHABILITATION	74	0	0	158	158	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	448	46	17,465	2,618	2,795	90.00
91.00	09100	EMERGENCY	1,130	129	62,801	1,929	6,672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	403	50	28,985	295	346	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,354	2,537	1,341,119	62,854	52,625	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	33	18,209	307	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,636	359	155,330	11,180	2,838	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	51	7	6,317	1	21	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	197	11	14,493	1,309	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	259	0	193.03
194.00	07950	PARTNERSHIP HFC	6	17	6,317	13	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	29	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	23,327	2,964	1,541,785	75,923	55,484	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING	232,927					4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	284,499				5.00
7.00	00700	OPERATION OF PLANT	0	11,531	256,847			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	952	2,809	36,034		8.00
9.00	00900	HOUSEKEEPING	0	3,928	2,182	6,831	33,806	9.00
10.00	01000	DIETARY	0	2,875	4,578	743	614	10.00
11.00	01100	CAFETERIA	0	2,090	4,875	0	654	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,798	11,531	0	1,548	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,130	1,986	0	267	14.00
15.00	01500	PHARMACY	0	18,091	2,391	0	321	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,391	4,533	0	608	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,722	19,626	32,228	8,943	4,326	30.00
31.00	03100	INTENSIVE CARE UNIT	1,577	6,757	9,216	2,032	1,237	31.00
41.00	04100	SUBPROVIDER - IRF	1,981	4,057	7,904	1,551	1,061	41.00
43.00	04300	NURSERY	623	861	730	0	98	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,734	16,271	53,479	6,409	7,180	50.00
53.00	05300	ANESTHESIOLOGY	4,655	440	460	0	62	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,483	17,605	19,320	2,950	2,593	54.00
60.00	06000	LABORATORY	32,343	20,000	9,407	0	1,263	60.00
65.00	06500	RESPIRATORY THERAPY	6,240	5,956	437	0	59	65.00
66.00	06600	PHYSICAL THERAPY	4,139	5,165	7,407	208	994	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,203	1,413	1,560	0	209	67.00
68.00	06800	SPEECH PATHOLOGY	745	861	97	0	13	68.00
69.00	06900	ELECTROCARDIOLOGY	4,596	8,717	1,262	277	169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	150	309	213	0	29	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,520	11,119	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,851	3,568	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,557	774	0	0	0	73.00
76.00	03020	ONCOLOGY	857	1,692	8,179	0	1,098	76.00
76.97	07697	CARDIAC REHABILITATION	666	931	2,935	0	394	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,751	8,779	13,458	211	1,806	90.00
91.00	09100	EMERGENCY	28,055	12,227	11,610	5,354	1,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,456	4,225	1,525	0	205	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	220,904	205,139	216,312	35,509	28,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	774	1,516	0	203	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,933	71,322	30,298	525	4,067	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	90	525	470	0	63	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	2,204	5,647	0	758	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	4,093	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	215	2,604	0	349	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	227	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	232,927	284,499	256,847	36,034	33,806	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	113,198					10.00
11.00	01100	CAFETERIA	0	38,533				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,190	157,444			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	187	2,266	54,829		14.00
15.00	01500	PHARMACY	0	676	0	0	52,461	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,510	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,367	4,889	59,265	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,041	1,561	18,916	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	20,790	892	10,812	0	0	41.00
43.00	04300	NURSERY	0	199	2,416	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,668	32,336	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,905	0	0	0	54.00
60.00	06000	LABORATORY	0	3,229	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,252	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,171	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	300	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	168	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	624	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	77	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	54,829	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	52,461	73.00
76.00	03020	ONCOLOGY	0	351	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	180	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,493	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,593	31,433	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	896	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,198	29,011	157,444	54,829	52,461	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	270	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,788	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	108	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	1,546	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	3	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	807	0	0	0	194.04
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)	113,198	38,533	157,444	54,829	52,461	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,043					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,206	692,242	0	692,242		30.00
31.00	03100	INTENSIVE CARE UNIT	772	193,080	0	193,080		31.00
41.00	04100	SUBPROVIDER - IRF	969	128,999	0	128,999		41.00
43.00	04300	NURSERY	305	10,059	0	10,059		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,511	1,144,841	0	1,144,841		50.00
53.00	05300	ANESTHESIOLOGY	2,279	27,130	0	27,130		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,834	675,429	0	675,429		54.00
60.00	06000	LABORATORY	15,830	395,590	0	395,590		60.00
65.00	06500	RESPIRATORY THERAPY	3,054	92,148	0	92,148		65.00
66.00	06600	PHYSICAL THERAPY	2,026	105,644	0	105,644		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,078	26,491	0	26,491		67.00
68.00	06800	SPEECH PATHOLOGY	364	9,848	0	9,848		68.00
69.00	06900	ELECTROCARDIOLOGY	2,249	145,598	0	145,598		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73	7,232	0	7,232		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,638	103,711	0	103,711		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,395	8,492	0	8,492		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,635	76,651	0	76,651		73.00
76.00	03020	ONCOLOGY	419	86,645	0	86,645		76.00
76.97	07697	CARDIAC REHABILITATION	326	35,303	0	35,303		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,751	168,831	0	168,831		90.00
91.00	09100	EMERGENCY	13,731	285,407	0	285,407		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	713	48,749	0	48,749		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,158	4,468,120	0	4,468,120		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,660	0	35,660		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,841	612,011	0	612,011		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	44	11,229	0	11,229		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	61,640	0	61,640		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	4,352	0	4,352		193.03
194.00	07950	PARTNERSHIP HFC	0	25,881	0	25,881		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	256	0	256		194.03
194.04	07954	ATHLETIC TRAINERS	0	807	0	807		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	114,043	5,219,956	0	5,219,956		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
			1.00	1.01	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	276,616					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	76,991				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,575,452			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	0	1,147	39,031,814		4.00
4.01	00401	COMMUNICATIONS	393	0	0	131,632	1,357	4.01
4.02	00402	DATA PROCESSING	6,260	0	1,207,398	711,477	135	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	0	5,720	306,775	29	4.03
4.04	00404	ADMITTING	2,239	1,639	0	710,659	34	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	0	10,096	1,097,596	88	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	0	25,341	1,397,432	77	5.00
7.00	00700	OPERATION OF PLANT	24,960	11,123	38,869	629,953	49	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	0	4,280	99,953	5	8.00
9.00	00900	HOUSEKEEPING	1,867	834	3,851	711,551	14	9.00
10.00	01000	DIETARY	3,917	493	17,925	330,263	26	10.00
11.00	01100	CAFETERIA	4,171	0	0	488,289	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	28,254	1,554,624	46	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	28,498	79,668	0	14.00
15.00	01500	PHARMACY	2,046	0	4,817	475,658	23	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	6,960	621,668	37	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	17,413	112,519	4,143,710	105	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	7,886	30,741	1,193,087	28	31.00
41.00	04100	SUBPROVIDER - IRF	6,763	6,763	16,940	727,898	18	41.00
43.00	04300	NURSERY	625	0	0	149,719	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	714	384,940	1,782,710	88	50.00
53.00	05300	ANESTHESIOLOGY	394	0	12,257	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	10,735	296,632	2,054,053	52	54.00
60.00	06000	LABORATORY	8,049	6,162	121,958	1,630,801	68	60.00
65.00	06500	RESPIRATORY THERAPY	374	1,071	13,372	929,956	18	65.00
66.00	06600	PHYSICAL THERAPY	6,338	0	8,722	794,578	25	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	2,061	249,623	6	67.00
68.00	06800	SPEECH PATHOLOGY	83	83	323	140,072	6	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	88	29,313	479,947	43	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	182	1,597	49,165	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,117	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
76.00	03020	ONCOLOGY	6,999	0	1,868	240,419	37	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	8,920	123,432	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	441	14,265	749,603	21	90.00
91.00	09100	EMERGENCY	9,934	9,665	26,855	1,890,187	59	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	56	674,425	23	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,932	75,292	2,478,612	27,350,583	1,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	1,297	3,854	90,132	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	0	92,517	11,119,170	164	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	402	469	84,824	3	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	0	329,558	5	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	0	9,452	8	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	48,095	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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)	2,030,804	0	3,189,152	8,188,429	389,311	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
			1.00	1.01	2.00	4.00	4.01	
203.00		Unit cost multiplier (Wkst. B, Part I)	7.341600	0.000000	1.238288	0.209789	286.890936	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				23,327	2,964	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000598	2.184230	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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	4,149					4.02
4.03	00403	MATERIALS MANAGEMENT	109	3,600,300				4.03
4.04	00404	ADMITTING	103	12,918	213,844,005			4.04
4.05	00405	PATIENT ACCOUNTING	458	26,541	0	213,844,005		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	486	74,892	0	0	-3,744,788	5.00
7.00	00700	OPERATION OF PLANT	36	3,643	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24	15,893	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	91,615	0	0	0	9.00
10.00	01000	DIETARY	129	248,651	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	67	48,492	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	56,114	0	0	0	14.00
15.00	01500	PHARMACY	26	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	176	2,356	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	299	216,329	13,519,178	13,519,178	0	30.00
31.00	03100	INTENSIVE CARE UNIT	101	62,968	1,447,795	1,447,795	0	31.00
41.00	04100	SUBPROVIDER - IRF	19	16,538	1,818,844	1,818,844	0	41.00
43.00	04300	NURSERY	0	0	572,213	572,213	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	407	147,127	30,976,810	30,976,810	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,634	4,275,008	4,275,008	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168	193,866	38,964,355	38,964,355	0	54.00
60.00	06000	LABORATORY	187	1,190,271	29,699,667	29,699,667	0	60.00
65.00	06500	RESPIRATORY THERAPY	139	100,258	5,730,152	5,730,152	0	65.00
66.00	06600	PHYSICAL THERAPY	68	19,928	3,800,658	3,800,658	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	0	2,023,294	2,023,294	0	67.00
68.00	06800	SPEECH PATHOLOGY	17	18	683,762	683,762	0	68.00
69.00	06900	ELECTROCARDIOLOGY	217	64,736	4,220,376	4,220,376	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8	1,198	137,496	137,496	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	135,686	10,578,304	10,578,304	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,617,894	2,617,894	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,449,137	12,449,137	0	73.00
76.00	03020	ONCOLOGY	53	10,815	786,780	786,780	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,508	611,835	611,835	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	47	124,153	10,790,441	10,790,441	0	90.00
91.00	09100	EMERGENCY	169	91,493	25,762,302	25,762,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	78	13,972	1,336,914	1,336,914	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,609	2,980,613	202,803,215	202,803,215	-3,744,788	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49	14,559	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	418	530,150	10,958,216	10,958,216	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	17	39	82,574	82,574	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	39	62,068	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	12,264	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	17	607	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,199,995	549,917	981,819	2,426,921		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	771.268980	0.152742	0.004591	0.011349		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,541,785	75,923	55,484	232,927		204.00

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		Cost Center Description	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
205.00		Unit cost multiplier (Wkst. B, Part II)	371.604001	0.021088	0.000259	0.001089		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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
			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
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	72,904,826					5.00
7.00	00700	OPERATION OF PLANT	2,955,159	219,778				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	244,073	2,404	391,523			8.00
9.00	00900	HOUSEKEEPING	1,006,660	1,867	74,218	215,507		9.00
10.00	01000	DIETARY	736,707	3,917	8,074	3,917	7,955	10.00
11.00	01100	CAFETERIA	535,517	4,171	0	4,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,254,724	9,867	0	9,867	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	289,713	1,699	0	1,699	0	14.00
15.00	01500	PHARMACY	4,636,320	2,046	0	2,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,125,380	3,879	0	3,879	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,029,755	27,577	97,150	27,577	5,437	30.00
31.00	03100	INTENSIVE CARE UNIT	1,731,597	7,886	22,083	7,886	1,057	31.00
41.00	04100	SUBPROVIDER - IRF	1,039,699	6,763	16,853	6,763	1,461	41.00
43.00	04300	NURSERY	220,722	625	0	625	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,169,922	45,761	69,641	45,761	0	50.00
53.00	05300	ANESTHESIOLOGY	112,663	394	0	394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,511,816	16,532	32,056	16,532	0	54.00
60.00	06000	LABORATORY	5,125,469	8,049	0	8,049	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,526,482	374	0	374	0	65.00
66.00	06600	PHYSICAL THERAPY	1,323,640	6,338	2,265	6,338	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,201	1,335	0	1,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	220,620	83	0	83	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,933	1,080	3,008	1,080	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,154	182	0	182	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,849,488	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	914,360	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	198,439	0	0	0	0	73.00
76.00	03020	ONCOLOGY	433,519	6,999	0	6,999	0	76.00
76.97	07697	CARDIAC REHABILITATION	238,719	2,511	0	2,511	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,249,968	11,516	2,291	11,516	0	90.00
91.00	09100	EMERGENCY	3,133,566	9,934	58,177	9,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,082,757	1,305	0	1,305	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,572,742	185,094	385,816	180,823	7,955	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	198,445	1,297	0	1,297	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,272,158	25,925	5,707	25,925	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	134,473	402	0	402	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	564,757	4,832	0	4,832	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	1,048,863	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	55,203	2,228	0	2,228	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	58,185	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,744,788	3,106,951	290,595	1,139,846	856,633	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.051365	14.136770	0.742217	5.289137	107.684852	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	284,499	256,847	36,034	33,806	113,198	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003902	1.168666	0.092035	0.156867	14.229793	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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	770,785					11.00
13.00	01300	NURSING ADMINISTRATION	23,804	259,825				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,739	3,739	100			14.00
15.00	01500	PHARMACY	13,513	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,212	0	0	0	213,844,005	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	97,804	97,804	0	0	13,519,178	30.00
31.00	03100	INTENSIVE CARE UNIT	31,216	31,216	0	0	1,447,795	31.00
41.00	04100	SUBPROVIDER - IRF	17,843	17,843	0	0	1,818,844	41.00
43.00	04300	NURSERY	3,987	3,987	0	0	572,213	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,363	53,363	0	0	30,976,810	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,275,008	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,114	0	0	0	38,964,355	54.00
60.00	06000	LABORATORY	64,581	0	0	0	29,699,667	60.00
65.00	06500	RESPIRATORY THERAPY	25,046	0	0	0	5,730,152	65.00
66.00	06600	PHYSICAL THERAPY	23,418	0	0	0	3,800,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,998	0	0	0	2,023,294	67.00
68.00	06800	SPEECH PATHOLOGY	3,363	0	0	0	683,762	68.00
69.00	06900	ELECTROCARDIOLOGY	12,481	0	0	0	4,220,376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,546	0	0	0	137,496	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	10,578,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,617,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	12,449,137	73.00
76.00	03020	ONCOLOGY	7,031	0	0	0	786,780	76.00
76.97	07697	CARDIAC REHABILITATION	3,605	0	0	0	611,835	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,863	0	0	0	10,790,441	90.00
91.00	09100	EMERGENCY	51,873	51,873	0	0	25,762,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	17,918	0	0	0	1,336,914	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	580,318	259,825	100	100	202,803,215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,406	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	135,766	0	0	0	10,958,216	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	2,165	0	0	0	82,574	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	30,931	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	59	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	16,140	0	0	0	0	194.04
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)	644,049	2,582,104	377,880	4,925,502	1,283,783	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.835575	9.937858	3,778.800000	49,255.020000	0.006003	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	38,533	157,444	54,829	52,461	114,043	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.049992	0.605962	548.290000	524.610000	0.000533	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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		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	7,616,245		7,616,245	0	7,616,245	30.00
31.00	03100	INTENSIVE CARE UNIT	2,448,940		2,448,940	0	2,448,940	31.00
41.00	04100	SUBPROVIDER - IRF	1,597,466		1,597,466	0	1,597,466	41.00
43.00	04300	NURSERY	290,588		290,588	0	290,588	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,085,603		6,085,603	0	6,085,603	50.00
53.00	05300	ANESTHESIOLOGY	151,767		151,767	0	151,767	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,371,046		5,371,046	0	5,371,046	54.00
60.00	06000	LABORATORY	5,777,347		5,777,347	0	5,777,347	60.00
65.00	06500	RESPIRATORY THERAPY	1,667,481	0	1,667,481	0	1,667,481	65.00
66.00	06600	PHYSICAL THERAPY	1,558,814	0	1,558,814	0	1,558,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	423,897	0	423,897	0	423,897	67.00
68.00	06800	SPEECH PATHOLOGY	240,479	0	240,479	0	240,479	68.00
69.00	06900	ELECTROCARDIOLOGY	2,407,656		2,407,656	0	2,407,656	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,873		88,873	0	88,873	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,437,234		3,437,234	0	3,437,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	977,041		977,041	0	977,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,208,866		5,208,866	0	5,208,866	73.00
76.00	03020	ONCOLOGY	602,347		602,347	0	602,347	76.00
76.97	07697	CARDIAC REHABILITATION	306,444		306,444	0	306,444	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,680,675		2,680,675	0	2,680,675	90.00
91.00	09100	EMERGENCY	4,244,181		4,244,181	0	4,244,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,045,924		1,045,924		1,045,924	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,186,720		1,186,720		1,186,720	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	55,415,634	0	55,415,634	0	55,415,634	200.00
201.00		Less Observation Beds	1,045,924		1,045,924		1,045,924	201.00
202.00		Total (see instructions)	54,369,710	0	54,369,710	0	54,369,710	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,402,865		11,402,865			30.00
31.00	03100	INTENSIVE CARE UNIT	1,447,795		1,447,795			31.00
41.00	04100	SUBPROVIDER - IRF	1,818,844		1,818,844			41.00
43.00	04300	NURSERY	572,213		572,213			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,662,910	25,313,901	30,976,811	0.196457	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	743,728	3,531,280	4,275,008	0.035501	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,470,080	34,492,577	38,962,657	0.137851	0.000000	54.00
60.00	06000	LABORATORY	5,958,454	23,741,213	29,699,667	0.194526	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,970,072	2,757,283	5,727,355	0.291143	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,217,610	2,583,048	3,800,658	0.410143	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,204,787	818,507	2,023,294	0.209508	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	366,175	317,587	683,762	0.351700	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	926,449	3,861,999	4,788,448	0.502805	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,076	91,420	137,496	0.646368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,968,953	7,609,352	10,578,305	0.324932	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	840,657	1,777,237	2,617,894	0.373216	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,197,479	8,251,358	12,448,837	0.418422	0.000000	73.00
76.00	03020	ONCOLOGY	1,294	678,019	679,313	0.886700	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	2,458	609,047	611,505	0.501131	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,891	10,645,113	10,652,004	0.251659	0.000000	90.00
91.00	09100	EMERGENCY	3,346,576	22,415,675	25,762,251	0.164744	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,160	1,071,166	1,219,326	0.857789	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,336,914	1,336,914			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,320,526	151,902,696	202,223,222			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,320,526	151,902,696	202,223,222			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.196457		50.00
53.00	05300	ANESTHESIOLOGY	0.035501		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137851		54.00
60.00	06000	LABORATORY	0.194526		60.00
65.00	06500	RESPIRATORY THERAPY	0.291143		65.00
66.00	06600	PHYSICAL THERAPY	0.410143		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209508		67.00
68.00	06800	SPEECH PATHOLOGY	0.351700		68.00
69.00	06900	ELECTROCARDIOLOGY	0.502805		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.646368		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324932		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.373216		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418422		73.00
76.00	03020	ONCOLOGY	0.886700		76.00
76.97	07697	CARDIAC REHABILITATION	0.501131		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.251659		90.00
91.00	09100	EMERGENCY	0.164744		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.857789		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 3:43 pm

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	7,616,245		7,616,245	0	7,616,245	30.00
31.00	03100	INTENSIVE CARE UNIT	2,448,940		2,448,940	0	2,448,940	31.00
41.00	04100	SUBPROVIDER - IRF	1,597,466		1,597,466	0	1,597,466	41.00
43.00	04300	NURSERY	290,588		290,588	0	290,588	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,085,603		6,085,603	0	6,085,603	50.00
53.00	05300	ANESTHESIOLOGY	151,767		151,767	0	151,767	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,371,046		5,371,046	0	5,371,046	54.00
60.00	06000	LABORATORY	5,777,347		5,777,347	0	5,777,347	60.00
65.00	06500	RESPIRATORY THERAPY	1,667,481	0	1,667,481	0	1,667,481	65.00
66.00	06600	PHYSICAL THERAPY	1,558,814	0	1,558,814	0	1,558,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	423,897	0	423,897	0	423,897	67.00
68.00	06800	SPEECH PATHOLOGY	240,479	0	240,479	0	240,479	68.00
69.00	06900	ELECTROCARDIOLOGY	2,407,656		2,407,656	0	2,407,656	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,873		88,873	0	88,873	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,437,234		3,437,234	0	3,437,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	977,041		977,041	0	977,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,208,866		5,208,866	0	5,208,866	73.00
76.00	03020	ONCOLOGY	602,347		602,347	0	602,347	76.00
76.97	07697	CARDIAC REHABILITATION	306,444		306,444	0	306,444	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,680,675		2,680,675	0	2,680,675	90.00
91.00	09100	EMERGENCY	4,244,181		4,244,181	0	4,244,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,045,924		1,045,924		1,045,924	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,186,720		1,186,720		1,186,720	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	55,415,634	0	55,415,634	0	55,415,634	200.00
201.00		Less Observation Beds	1,045,924		1,045,924		1,045,924	201.00
202.00		Total (see instructions)	54,369,710	0	54,369,710	0	54,369,710	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 3:43 pm

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	11,402,865		11,402,865			30.00
31.00	03100	INTENSIVE CARE UNIT	1,447,795		1,447,795			31.00
41.00	04100	SUBPROVIDER - IRF	1,818,844		1,818,844			41.00
43.00	04300	NURSERY	572,213		572,213			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,662,910	25,313,901	30,976,811	0.196457	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	743,728	3,531,280	4,275,008	0.035501	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,470,080	34,492,577	38,962,657	0.137851	0.000000	54.00
60.00	06000	LABORATORY	5,958,454	23,741,213	29,699,667	0.194526	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,970,072	2,757,283	5,727,355	0.291143	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,217,610	2,583,048	3,800,658	0.410143	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,204,787	818,507	2,023,294	0.209508	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	366,175	317,587	683,762	0.351700	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	926,449	3,861,999	4,788,448	0.502805	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,076	91,420	137,496	0.646368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,968,953	7,609,352	10,578,305	0.324932	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	840,657	1,777,237	2,617,894	0.373216	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,197,479	8,251,358	12,448,837	0.418422	0.000000	73.00
76.00	03020	ONCOLOGY	1,294	678,019	679,313	0.886700	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	2,458	609,047	611,505	0.501131	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,891	10,645,113	10,652,004	0.251659	0.000000	90.00
91.00	09100	EMERGENCY	3,346,576	22,415,675	25,762,251	0.164744	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,160	1,071,166	1,219,326	0.857789	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,336,914	1,336,914			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,320,526	151,902,696	202,223,222			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,320,526	151,902,696	202,223,222			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 3:43 pm

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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
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
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	692,242	0	692,242	6,408	108.03	30.00
31.00	INTENSIVE CARE UNIT	193,080		193,080	729	264.86	31.00
41.00	SUBPROVIDER - IRF	128,999	0	128,999	1,378	93.61	41.00
43.00	NURSERY	10,059		10,059	671	14.99	43.00
200.00	Total (lines 30 through 199)	1,024,380		1,024,380	9,186		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,366	255,599	30.00
31.00	INTENSIVE CARE UNIT	455	120,511	31.00
41.00	SUBPROVIDER - IRF	553	51,766	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	3,374	427,876	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,144,841	30,976,811	0.036958	1,856,863	68,626	50.00
53.00	05300	ANESTHESIOLOGY	27,130	4,275,008	0.006346	67,429	428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,429	38,962,657	0.017335	2,053,709	35,601	54.00
60.00	06000	LABORATORY	395,590	29,699,667	0.013320	2,718,390	36,209	60.00
65.00	06500	RESPIRATORY THERAPY	92,148	5,727,355	0.016089	1,228,913	19,772	65.00
66.00	06600	PHYSICAL THERAPY	105,644	3,800,658	0.027796	258,538	7,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,491	2,023,294	0.013093	228,996	2,998	67.00
68.00	06800	SPEECH PATHOLOGY	9,848	683,762	0.014403	51,767	746	68.00
69.00	06900	ELECTROCARDIOLOGY	145,598	4,788,448	0.030406	668,575	20,329	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,232	137,496	0.052598	1,581	83	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,711	10,578,305	0.009804	1,538,882	15,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,492	2,617,894	0.003244	73,427	238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,651	12,448,837	0.006157	1,897,882	11,685	73.00
76.00	03020	ONCOLOGY	86,645	679,313	0.127548	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,303	611,505	0.057731	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	168,831	10,652,004	0.015850	6,812	108	90.00
91.00	09100	EMERGENCY	285,407	25,762,251	0.011078	1,488,474	16,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	95,064	1,219,326	0.077964	124,330	9,693	92.00
200.00		Total (lines 50 through 199)	3,490,055	185,644,591		14,264,568	245,278	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,408	0.00	2,366	30.00
31.00	03100	INTENSIVE CARE UNIT		0	729	0.00	455	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,378	0.00	553	41.00
43.00	04300	NURSERY		0	671	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,186		3,374	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
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
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: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,976,811	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,275,008	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,962,657	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	29,699,667	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,727,355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,800,658	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,023,294	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	683,762	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,788,448	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	137,496	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,578,305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,617,894	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,448,837	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	679,313	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	611,505	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,652,004	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,762,251	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,219,326	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	185,644,591		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,856,863	0	5,115,389	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	67,429	0	698,723	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,053,709	0	8,425,766	0	54.00
60.00	06000	LABORATORY	0.000000	2,718,390	0	2,199,803	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,228,913	0	655,968	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	258,538	0	5,281	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	228,996	0	4,860	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	51,767	0	931	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	668,575	0	1,509,515	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,581	0	30,056	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,538,882	0	1,127,168	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	73,427	0	509,330	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,897,882	0	3,114,226	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76,758	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	149,910	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	6,812	0	2,696,609	0	90.00
91.00	09100	EMERGENCY	0.000000	1,488,474	0	3,612,560	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	124,330	0	529,564	0	92.00
200.00		Total (lines 50 through 199)		14,264,568	0	30,462,417	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.196457	5,115,389	0	0	1,004,954	50.00
53.00	05300	ANESTHESIOLOGY	0.035501	698,723	0	0	24,805	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137851	8,425,766	0	0	1,161,500	54.00
60.00	06000	LABORATORY	0.194526	2,199,803	0	0	427,919	60.00
65.00	06500	RESPIRATORY THERAPY	0.291143	655,968	0	0	190,980	65.00
66.00	06600	PHYSICAL THERAPY	0.410143	5,281	0	0	2,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209508	4,860	0	0	1,018	67.00
68.00	06800	SPEECH PATHOLOGY	0.351700	931	0	0	327	68.00
69.00	06900	ELECTROCARDIOLOGY	0.502805	1,509,515	0	0	758,992	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.646368	30,056	0	0	19,427	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324932	1,127,168	0	0	366,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.373216	509,330	0	0	190,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418422	3,114,226	219	1,921	1,303,061	73.00
76.00	03020	ONCOLOGY	0.886700	76,758	0	0	68,061	76.00
76.97	07697	CARDIAC REHABILITATION	0.501131	149,910	0	0	75,125	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.251659	2,696,609	1,450	0	678,626	90.00
91.00	09100	EMERGENCY	0.164744	3,612,560	0	0	595,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.857789	529,564	0	0	454,254	92.00
200.00		Subtotal (see instructions)		30,462,417	1,669	1,921	7,322,706	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		30,462,417	1,669	1,921	7,322,706	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
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	92	804		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	365	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	457	804		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	457	804		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,144,841	30,976,811	0.036958	5,435	201	50.00
53.00	05300	ANESTHESIOLOGY	27,130	4,275,008	0.006346	942	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,429	38,962,657	0.017335	27,737	481	54.00
60.00	06000	LABORATORY	395,590	29,699,667	0.013320	144,054	1,919	60.00
65.00	06500	RESPIRATORY THERAPY	92,148	5,727,355	0.016089	65,814	1,059	65.00
66.00	06600	PHYSICAL THERAPY	105,644	3,800,658	0.027796	275,007	7,644	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,491	2,023,294	0.013093	284,811	3,729	67.00
68.00	06800	SPEECH PATHOLOGY	9,848	683,762	0.014403	95,061	1,369	68.00
69.00	06900	ELECTROCARDIOLOGY	145,598	4,788,448	0.030406	8,085	246	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,232	137,496	0.052598	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,711	10,578,305	0.009804	23,679	232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,492	2,617,894	0.003244	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,651	12,448,837	0.006157	66,475	409	73.00
76.00	03020	ONCOLOGY	86,645	679,313	0.127548	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,303	611,505	0.057731	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	168,831	10,652,004	0.015850	0	0	90.00
91.00	09100	EMERGENCY	285,407	25,762,251	0.011078	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,219,326	0.000000	3,205	0	92.00
200.00		Total (lines 50 through 199)	3,394,991	185,644,591		1,000,305	17,295	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001
Component CCN: 15-T001
Period: From 01/01/2017 To 12/31/2017
Worksheet D Part IV
Date/Time Prepared: 5/25/2018 3:43 pm
Title XVIII
Subprovider - IRF
PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
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
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: 15-0001
Component CCN: 15-T001
Period: From 01/01/2017 To 12/31/2017
Worksheet D Part IV
Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	30,976,811	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,275,008	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,962,657	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	29,699,667	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,727,355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,800,658	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,023,294	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	683,762	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,788,448	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	137,496	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,578,305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,617,894	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,448,837	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	679,313	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	611,505	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10,652,004	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,762,251	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,219,326	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	185,644,591		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,435	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	942	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	27,737	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	144,054	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65,814	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	275,007	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	284,811	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	95,061	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,085	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	23,679	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	66,475	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
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
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,205	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,000,305	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,408	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,408	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)	5,528	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,366	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,616,245	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,616,245	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)	7,616,245	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)	1,188.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,812,109	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)	2,812,109	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,448,940	729	3,359.31	455	1,528,486	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)	3,721,418	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,062,013	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)	376,110	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	245,278	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	621,388	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,440,625	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)	880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,188.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,045,924	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	692,242	7,616,245	0.090890	1,045,924	95,064	90.00
91.00	Nursing School cost	0	7,616,245	0.000000	1,045,924	0	91.00
92.00	Allied health cost	0	7,616,245	0.000000	1,045,924	0	92.00
93.00	All other Medical Education	0	7,616,245	0.000000	1,045,924	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,378	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,378	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)	1,378	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	553	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,597,466	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,597,466	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)	1,597,466	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)	1,159.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	641,071	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)	641,071	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	300,326	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	941,397	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)	51,766	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,295	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	69,061	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	872,336	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	128,999	1,597,466	0.080752	0	0	90.00
91.00	Nursing School cost	0	1,597,466	0.000000	0	0	91.00
92.00	Allied health cost	0	1,597,466	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,597,466	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

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)	6,408	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,408	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)	5,528	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	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)	671	15.00
16.00	Nursery days (title V or XIX only)	55	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,616,245	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,616,245	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)	7,616,245	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)	1,188.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	32,091	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)	32,091	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

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)	290,588	671	433.07	55	23,819	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,448,940	729	3,359.31	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	68,382	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	124,292	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)	880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,188.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,045,924	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

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	692,242	7,616,245	0.090890	1,045,924	95,064	90.00
91.00	Nursing School cost	0	7,616,245	0.000000	1,045,924	0	91.00
92.00	Allied health cost	0	7,616,245	0.000000	1,045,924	0	92.00
93.00	All other Medical Education	0	7,616,245	0.000000	1,045,924	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 3:43 pm
	Title XIX	Subprovider - IRF	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)	1,378	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,378	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)	1,378	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	671	15.00
16.00	Nursery days (title V or XIX only)	55	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,597,466	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,597,466	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)	1,597,466	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)	1,159.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	24,262	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	24,262	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XIX | Subprovider - IRF | 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	128,999	1,597,466	0.080752	0	0	90.00
91.00	Nursing School cost	0	1,597,466	0.000000	0	0	91.00
92.00	Allied health cost	0	1,597,466	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,597,466	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,614,206		30.00
31.00	03100	INTENSIVE CARE UNIT		595,600		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196457	1,856,863	364,794	50.00
53.00	05300	ANESTHESIOLOGY	0.035501	67,429	2,394	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137851	2,053,709	283,106	54.00
60.00	06000	LABORATORY	0.194526	2,718,390	528,798	60.00
65.00	06500	RESPIRATORY THERAPY	0.291143	1,228,913	357,789	65.00
66.00	06600	PHYSICAL THERAPY	0.410143	258,538	106,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209508	228,996	47,976	67.00
68.00	06800	SPEECH PATHOLOGY	0.351700	51,767	18,206	68.00
69.00	06900	ELECTROCARDIOLOGY	0.502805	668,575	336,163	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.646368	1,581	1,022	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324932	1,538,882	500,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.373216	73,427	27,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418422	1,897,882	794,116	73.00
76.00	03020	ONCOLOGY	0.886700	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501131	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251659	6,812	1,714	90.00
91.00	09100	EMERGENCY	0.164744	1,488,474	245,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.857789	124,330	106,649	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,264,568	3,721,418	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		14,264,568		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		702,139		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196457	5,435	1,068	50.00
53.00	05300	ANESTHESIOLOGY	0.035501	942	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137851	27,737	3,824	54.00
60.00	06000	LABORATORY	0.194526	144,054	28,022	60.00
65.00	06500	RESPIRATORY THERAPY	0.291143	65,814	19,161	65.00
66.00	06600	PHYSICAL THERAPY	0.410143	275,007	112,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209508	284,811	59,670	67.00
68.00	06800	SPEECH PATHOLOGY	0.351700	95,061	33,433	68.00
69.00	06900	ELECTROCARDIOLOGY	0.502805	8,085	4,065	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.646368	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324932	23,679	7,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.373216	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418422	66,475	27,815	73.00
76.00	03020	ONCOLOGY	0.886700	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501131	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251659	0	0	90.00
91.00	09100	EMERGENCY	0.164744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.857789	3,205	2,749	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,000,305	300,326	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,000,305		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 3:43 pm

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		228,021		30.00
31.00	03100	INTENSIVE CARE UNIT		4,356		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196457	117,593	23,102	50.00
53.00	05300	ANESTHESIOLOGY	0.035501	15,936	566	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137851	26,325	3,629	54.00
60.00	06000	LABORATORY	0.194526	58,589	11,397	60.00
65.00	06500	RESPIRATORY THERAPY	0.291143	11,178	3,254	65.00
66.00	06600	PHYSICAL THERAPY	0.410143	976	400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209508	810	170	67.00
68.00	06800	SPEECH PATHOLOGY	0.351700	204	72	68.00
69.00	06900	ELECTROCARDIOLOGY	0.502805	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.646368	70	45	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324932	14,444	4,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.373216	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418422	40,079	16,770	73.00
76.00	03020	ONCOLOGY	0.886700	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501131	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251659	0	0	90.00
91.00	09100	EMERGENCY	0.164744	26,005	4,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.857789	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		312,209	68,382	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)		312,209		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 3:43 pm

Title XIX | Subprovider - IRF | 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
41.00	04100	SUBPROVIDER - IRF		78,512		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196457	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035501	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137851	0	0	54.00
60.00	06000	LABORATORY	0.194526	2,391	465	60.00
65.00	06500	RESPIRATORY THERAPY	0.291143	5,115	1,489	65.00
66.00	06600	PHYSICAL THERAPY	0.410143	32,654	13,393	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.209508	32,321	6,772	67.00
68.00	06800	SPEECH PATHOLOGY	0.351700	5,997	2,109	68.00
69.00	06900	ELECTROCARDIOLOGY	0.502805	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.646368	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324932	104	34	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.373216	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418422	0	0	73.00
76.00	03020	ONCOLOGY	0.886700	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.501131	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251659	0	0	90.00
91.00	09100	EMERGENCY	0.164744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.857789	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		78,582	24,262	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)		78,582		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,311,560	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	25,235	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	80.59	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.16	31.00
32.00	Sum of lines 30 and 31	21.73	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.14	33.00
34.00	Disproportionate share adjustment (see instructions)	94,811	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	287,693	605,548	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	215,179	152,631	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	367,810		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	5,799,416		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	5,799,416	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	433,289	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,232,705	59.00
60.00	Primary payer payments	3,862	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,228,843	61.00
62.00	Deductibles billed to program beneficiaries	764,428	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	73,229	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	47,599	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	73,229	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,512,014	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	24,774	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,536,788	71.00
71.01	Sequestration adjustment (see instructions)		110,736	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		5,453,961	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-27,909	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		94,228	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2018 3:43 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,311,560	0		5,311,560	5,311,560	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	25,235	0	0	25,235	25,235	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0714	0.0714	0.0714	0.0714		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	94,811	0	0	94,811	94,811	11.00
11.01	Uncompensated care payments	36.00	367,810	0	215,179	152,631	367,810	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,799,416	0	215,179	5,584,237	5,799,416	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,799,416	0	215,179	5,584,237	5,799,416	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	433,289	0	0	433,289	433,289	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2018 3:43 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	215,179	6,017,526	6,232,705	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	430,835	0	0	430,835	430,835	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,454	0	0	2,454	2,454	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	433,289	0	0	433,289	433,289	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.092143	0.103036		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			19,827		19,827	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				620,022	620,022	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2018 3:43 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,311,560		5,311,560	5,311,560	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	25,235	0	25,235	25,235	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0714	0.0714	0.0714		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	94,811	0	94,811	94,811	11.00
11.01	Uncompensated care payments	36.00	367,810	215,179	152,631	367,810	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,799,416	215,179	5,584,237	5,799,416	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,799,416	215,179	5,584,237	5,799,416	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	433,289	0	433,289	433,289	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			215,179	6,017,526	6,232,705	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2018 3:43 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	430,835	0	430,835	430,835	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,454	0	2,454	2,454	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	433,289	0	433,289	433,289	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	24,774	0	24,774	24,774	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,261	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,322,706	2.00
3.00	OPPS payments	5,666,259	3.00
4.00	Outlier payment (see instructions)	31,391	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)	1,261	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,590	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)	3,590	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)	3,590	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,329	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)	1,261	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)	5,697,650	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,166,093	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)	4,532,818	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)	4,532,818	30.00
31.00	Primary payer payments	241	31.00
32.00	Subtotal (line 30 minus line 31)	4,532,577	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)	139,102	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	90,416	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	139,102	36.00
37.00	Subtotal (see instructions)	4,622,993	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)	4,622,993	40.00
40.01	Sequestration adjustment (see instructions)	92,460	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,511,190	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	19,343	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,374,146		4,441,508	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	12/31/2017	79,815	12/31/2017	69,682	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)		79,815		69,682	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)		5,453,961		4,511,190	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		19,343	6.01
6.02	SETTLEMENT TO PROGRAM		27,909		0	6.02
7.00	Total Medicare program liability (see instructions)		5,426,052		4,530,533	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: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		860,371		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)		860,371		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		12,159		0	6.02
7.00	Total Medicare program liability (see instructions)		848,212		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: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	766,864	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0201	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	29,831	3.00
4.00	Outlier Payments	75,407	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.775342	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	872,102	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	872,102	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	872,102	19.00
20.00	Deductibles	6,580	20.00
21.00	Subtotal (line 19 minus line 20)	865,522	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	865,522	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	865,522	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	865,522	32.00
32.01	Sequestration adjustment (see instructions)	17,310	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	860,371	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-12,159	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,072	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	75,407	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 5/25/2018 3:43 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	124,292		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	124,292	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	124,292	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	232,377		8.00
9.00	Ancillary service charges	312,209	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	544,586	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	544,586	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	420,294	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	124,292	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	124,292	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	124,292	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	124,292	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	124,292	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	124,292	0	40.00
41.00	Interim payments	265,302	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-141,010	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2018 3:43 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	24,262		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	24,262	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	24,262	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	78,512		8.00
9.00	Ancillary service charges	78,582	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	157,094	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	157,094	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	132,832	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	24,262	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	24,262	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	24,262	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	24,262	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	24,262	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	24,262	0	40.00
41.00	Interim payments	64,867	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-40,605	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/25/2018 3:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	40,559,390	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	15,965,780	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,982,884	0	0	0	7.00
8.00	Prepaid expenses	1,381,568	0	0	0	8.00
9.00	Other current assets	0	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)	59,889,622	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,743,426	0	0	0	12.00
13.00	Land improvements	2,807,066	0	0	0	13.00
14.00	Accumulated depreciation	-1,155,355	0	0	0	14.00
15.00	Buildings	72,464,758	0	0	0	15.00
16.00	Accumulated depreciation	-34,605,601	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	13,007,605	0	0	0	19.00
20.00	Accumulated depreciation	-10,766,528	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	61,552,003	0	0	0	23.00
24.00	Accumulated depreciation	-32,013,696	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	76,033,678	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	2,797,202	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,797,202	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	138,720,502	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,220,818	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,095,586	0	0	0	38.00
39.00	Payroll taxes payable	862,369	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-38,188,500	0	0	0	43.00
44.00	Other current liabilities	17,509	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-28,992,218	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	265,571	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,493	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	288,064	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-28,704,154	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	167,424,656				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)	167,424,656	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	138,720,502	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/25/2018 3:43 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		155,993,557		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,431,099				2.00
3.00	Total (sum of line 1 and line 2)		167,424,656		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)		167,424,656		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		167,424,656		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/25/2018 3:43 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,975,078		11,975,078	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,818,844		1,818,844	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)	13,793,922		13,793,922	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,447,795		1,447,795	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,447,795		1,447,795	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,241,717		15,241,717	17.00
18.00	Ancillary services	31,563,131	115,879,527	147,442,658	18.00
19.00	Outpatient services	3,501,627	34,131,954	37,633,581	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		1,336,914	1,336,914	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	NRCC	15,521	11,025,269	11,040,790	27.00
27.01	PRO FEES	629,194	1,738,478	2,367,672	27.01
27.02	OTHER	7,009	32,340	39,349	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	50,958,199	164,144,482	215,102,681	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		83,353,930		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)		83,353,930		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/25/2018 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	215,102,681	1.00
2.00	Less contractual allowances and discounts on patients' accounts	140,821,409	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,281,272	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	83,353,930	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,072,658	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,142,399	24.00
24.01	NON-OPERATING INCOME	2,471,361	24.01
24.02	UPL INCOME	16,889,997	24.02
25.00	Total other income (sum of lines 6-24)	20,503,757	25.00
26.00	Total (line 5 plus line 25)	11,431,099	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)	11,431,099	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/25/2018 3:43 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	195,663	0	38,594	0	117,672	351,929	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	243,370	0	0	0	0	243,370	6.00
7.00	Physical Therapy	165,862	0	0	0	0	165,862	7.00
8.00	Occupational Therapy	65,490	0	0	0	0	65,490	8.00
9.00	Speech Pathology	3,537	0	0	0	0	3,537	9.00
10.00	Medical Social Services	503	0	0	0	0	503	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	10,727	10,727	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	674,425	0	38,594	0	128,399	841,418	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	351,929	0	351,929			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	243,370	0	243,370			6.00
7.00	Physical Therapy	0	165,862	0	165,862			7.00
8.00	Occupational Therapy	0	65,490	0	65,490			8.00
9.00	Speech Pathology	0	3,537	0	3,537			9.00
10.00	Medical Social Services	0	503	0	503			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	10,727	0	10,727			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	841,418	0	841,418			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	351,929	0	0	0	0	351,929	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	243,370	0	0	0	0	243,370	6.00
7.00	Physical Therapy	165,862	0	0	0	0	165,862	7.00
8.00	Occupational Therapy	65,490	0	0	0	0	65,490	8.00
9.00	Speech Pathology	3,537	0	0	0	0	3,537	9.00
10.00	Medical Social Services	503	0	0	0	0	503	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	10,727	0	0	0	0	10,727	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	841,418	0	0	0	0	841,418	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	351,929			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	174,977	418,347		6.00
7.00	Physical Therapy	119,250	285,112		7.00
8.00	Occupational Therapy	47,085	112,575		8.00
9.00	Speech Pathology	2,543	6,080		9.00
10.00	Medical Social Services	362	865		10.00
11.00	Home Health Aide	0	0		11.00
12.00	Supplies (see instructions)	7,712	18,439		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		841,418		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 5/25/2018 3:43 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-351,929	489,489	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	243,370	6.00
7.00	Physical Therapy	0	0	0	0	0	165,862	7.00
8.00	Occupational Therapy	0	0	0	0	0	65,490	8.00
9.00	Speech Pathology	0	0	0	0	0	3,537	9.00
10.00	Medical Social Services	0	0	0	0	0	503	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	10,727	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-351,929	489,489	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		351,929	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.718972	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part I Date/Time Prepared: 5/25/2018 3:43 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		0	1.00	1.01	2.00	4.00	4.01	
1.00	Administrative and General	0	9,581	0	69	141,487	6,598	1.00
2.00	Skilled Nursing Care	418,347	0	0	0	0	0	2.00
3.00	Physical Therapy	285,112	0	0	0	0	0	3.00
4.00	Occupational Therapy	112,575	0	0	0	0	0	4.00
5.00	Speech Pathology	6,080	0	0	0	0	0	5.00
6.00	Medical Social Services	865	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	18,439	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	841,418	9,581	0	69	141,487	6,598	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	
		4.02	4.03	4.04	4.05	4A.05	5.00	
1.00	Administrative and General	60,159	2,134	6,138	15,173	241,339	12,396	1.00
2.00	Skilled Nursing Care	0	0	0	0	418,347	21,490	2.00
3.00	Physical Therapy	0	0	0	0	285,112	14,645	3.00
4.00	Occupational Therapy	0	0	0	0	112,575	5,782	4.00
5.00	Speech Pathology	0	0	0	0	6,080	312	5.00
6.00	Medical Social Services	0	0	0	0	865	44	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	18,439	947	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	60,159	2,134	6,138	15,173	1,082,757	55,616	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

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	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	18,448	0	6,902	0	14,972	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	18,448	0	6,902	0	14,972	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	8,025	302,082	0	302,082	1.00
2.00	Skilled Nursing Care	0	0	0	439,837	0	439,837	2.00
3.00	Physical Therapy	0	0	0	299,757	0	299,757	3.00
4.00	Occupational Therapy	0	0	0	118,357	0	118,357	4.00
5.00	Speech Pathology	0	0	0	6,392	0	6,392	5.00
6.00	Medical Social Services	0	0	0	909	0	909	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	19,386	0	19,386	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	8,025	1,186,720	0	1,186,720	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-2
Part I
Date/Time Prepared:
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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	150,193	590,030				2.00
3.00	Physical Therapy	102,360	402,117				3.00
4.00	Occupational Therapy	40,416	158,773				4.00
5.00	Speech Pathology	2,183	8,575				5.00
6.00	Medical Social Services	310	1,219				6.00
7.00	Home Health Aide	0	0				7.00
8.00	Supplies (see instructions)	6,620	26,006				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
19.50	Telemedicine	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	302,082	1,186,720				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.341475					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part II Date/Time Prepared: 5/25/2018 3:43 pm

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	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
		1.00	1.01	2.00	4.00	4.01	4.02	
1.00	Administrative and General	1,305	0	56	674,425	23	78	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	56	674,425	23	78	20.00
21.00	Total cost to be allocated	9,581	0	69	141,487	6,598	60,159	21.00
22.00	Unit cost multiplier	7.341762	0.000000	1.232143	0.209789	286.869565	771.269231	22.00

	Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	
		4.03	4.04	4.05	5A	5.00	7.00	
1.00	Administrative and General	13,972	1,336,914	1,336,914	0	241,339	1,305	1.00
2.00	Skilled Nursing Care	0	0	0	0	418,347	0	2.00
3.00	Physical Therapy	0	0	0	0	285,112	0	3.00
4.00	Occupational Therapy	0	0	0	0	112,575	0	4.00
5.00	Speech Pathology	0	0	0	0	6,080	0	5.00
6.00	Medical Social Services	0	0	0	0	865	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	18,439	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	13,972	1,336,914	1,336,914		1,082,757	1,305	20.00
21.00	Total cost to be allocated	2,134	6,138	15,173		55,616	18,448	21.00
22.00	Unit cost multiplier	0.152734	0.004591	0.011349		0.051365	14.136398	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,305	0	17,918	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,305	0	17,918	0	0	20.00
21.00	Total cost to be allocated	0	6,902	0	14,972	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.288889	0.000000	0.835584	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)					
		15.00	16.00					
1.00	Administrative and General	0	1,336,914					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	1,336,914					20.00
21.00	Total cost to be allocated	0	8,025					21.00
22.00	Unit cost multiplier	0.000000	0.006003					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/25/2018 3:43 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	590,030		590,030	2,252	262.00	1.00
2.00	Physical Therapy	3.00	402,117	0	402,117	1,735	231.77	2.00
3.00	Occupational Therapy	4.00	158,773	0	158,773	903	175.83	3.00
4.00	Speech Pathology	5.00	8,575	0	8,575	37	231.76	4.00
5.00	Medical Social Services	6.00	1,219		1,219	4	304.75	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		1,160,714	0	1,160,714	4,931		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	42			8.00
8.01	Skilled Nursing Care		26900	0	1,062			8.01
9.00	Physical Therapy		18020	0	49			9.00
9.01	Physical Therapy		26900	0	850			9.01
10.00	Occupational Therapy		18020	0	44			10.00
10.01	Occupational Therapy		26900	0	515			10.01
11.00	Speech Pathology		18020	0	12			11.00
11.01	Speech Pathology		26900	0	35			11.01
12.00	Medical Social Services		18020	0	0			12.00
12.01	Medical Social Services		26900	0	2			12.01
13.00	Home Health Aide		18020	0	0			13.00
13.01	Home Health Aide		26900	0	0			13.01
14.00	Total (sum of lines 8-13)			0	2,611			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	26,006	0	26,006	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,104		0	289,248		1.00
2.00	Physical Therapy	0	899		0	208,361		2.00
3.00	Occupational Therapy	0	559		0	98,289		3.00
4.00	Speech Pathology	0	47		0	10,893		4.00
5.00	Medical Social Services	0	2		0	610		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	2,611		0	607,401		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/25/2018 3:43 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	289,248		1.00
2.00	Physical Therapy	208,361		2.00
3.00	Occupational Therapy	98,289		3.00
4.00	Speech Pathology	10,893		4.00
5.00	Medical Social Services	610		5.00
6.00	Home Health Aide	0		6.00
7.00	Total (sum of lines 1-6)	607,401		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-3
Part II
Date/Time Prepared:
5/25/2018 3:43 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.410143	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.209508	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.351700	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.324932	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.418422	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/25/2018 3:43 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	456,730	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	23,039	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	1,910	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	598	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,827	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	486,104	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	486,104	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	486,104	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	486,104	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	486,104	31.00
31.01	Sequestration adjustment (see instructions)	0	9,723	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	476,381	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/25/2018 3:43 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		476,381	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			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			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. H-4, Part II, column as appropriate, line 32)		0		476,381	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		476,381	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/25/2018 3:43 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	430,835	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,454	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	17.34	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	433,289	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00