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: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet S Parts I-III Date/Time Prepared: 7/31/2017 3:16 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/31/2017 Time: 3:16 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 KOSCIUSKO COMMUNITY HOSPITAL (15-0133) for the cost reporting period beginning 03/01/2016 and ending 02/28/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
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	11,153	-56,470	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	11,153	-56,470	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2017 3:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2101 EAST DUBOIS DRIVE	PO Box:			1.00
2.00	City: WARSAW	State: IN	Zip Code: 46580-	County: KOSCIUSKO	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	KOSCIUSKO COMMUNITY HOSPITAL	150133	99915	1	07/01/1966	O	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	03/01/2016	02/28/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	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.	544	1,081	1	0	276	78	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2017 3:14 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.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	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 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2017 3:14 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2017 3:14 pm

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

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

		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 Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	30,816	233,263	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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part I | Date/Time Prepared: 7/31/2017 3:14 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet S-2 Part I Date/Time Prepared: 7/31/2017 3:14 pm

		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)	10/01/2014	12/29/2014	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: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part II | Date/Time Prepared: 7/31/2017 3:14 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/22/2017	Y	06/22/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part II Date/Time Prepared: 7/31/2017 3:14 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2015	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COREY	WATKINS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4497	COREY_WATKINS@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-2 Part II Date/Time Prepared: 7/31/2017 3:14 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.	ASST MANAGER, REVENUE MANAGEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part I Date/Time Prepared: 7/31/2017 3:14 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	58	21,170	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)		58	21,170	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	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)		72	26,280	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		72				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part I | Date/Time Prepared: 7/31/2017 3:14 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)	3,116	1,080	8,757			1.00
2.00	HMO and other (see instructions)	2,547	236				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,116	1,080	8,757			7.00
8.00	INTENSIVE CARE UNIT	629	229	1,540			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		435	969			13.00
14.00	Total (see instructions)	3,745	1,744	11,266	0.00	421.19	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	421.19	27.00
28.00	Observation Bed Days		0	2,151			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part I | Date/Time Prepared: 7/31/2017 3:14 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,054	453	3,309	1.00
2.00	HMO and other (see instructions)			680	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,054	453	3,309	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part II Date/Time Prepared: 7/31/2017 3:14 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 II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	22,093,487	0	22,093,487	876,072.00	25.22	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		33,971	144,966	178,937	7,740.00	23.12	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		172,579	0	172,579	2,326.00	74.20	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		199,163	0	199,163	1,689.00	117.92	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		2,303,509	0	2,303,509	70,241.00	32.79	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)		5,278,020	0	5,278,020			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		46,600	0	46,600			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	159,508	0	159,508	6,248.00	25.53	26.00
27.00	Administrative & General	5.00	3,656,718	-315,430	3,341,288	131,720.00	25.37	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part II Date/Time Prepared: 7/31/2017 3:14 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	
28.00	Administrative & General under contract (see inst.)		6,777	0	6,777	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	502,604	0	502,604	24,505.00	20.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	504,093	0	504,093	38,971.00	12.94	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	560,547	-442,061	118,486	8,059.00	14.70	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	442,061	442,061	30,066.00	14.70	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,108,366	170,464	1,278,830	38,638.00	33.10	38.00
39.00	Central Services and Supply	14.00	226,693	0	226,693	14,221.00	15.94	39.00
40.00	Pharmacy	15.00	831,730	0	831,730	19,123.00	43.49	40.00
41.00	Medical Records & Medical Records Library	16.00	250,854	0	250,854	15,563.00	16.12	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: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part III Date/Time Prepared: 7/31/2017 3:14 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)		22,100,264	0	22,100,264	876,072.00	25.23	1.00
2.00	Excluded area salaries (see instructions)		33,971	144,966	178,937	7,740.00	23.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,066,293	-144,966	21,921,327	868,332.00	25.25	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,675,251	0	2,675,251	74,256.00	36.03	4.00
5.00	Subtotal wage-related costs (see inst.)		5,278,020	0	5,278,020	0.00	24.08	5.00
6.00	Total (sum of lines 3 thru 5)		30,019,564	-144,966	29,874,598	942,588.00	31.69	6.00
7.00	Total overhead cost (see instructions)		7,807,890	-144,966	7,662,924	327,114.00	23.43	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part IV Date/Time Prepared: 7/31/2017 3:14 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	389,248	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)	2,963,897	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	22,802	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	20,391	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	791	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	30,475	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	145,287	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,261,638	17.00
18.00	Medicare Taxes - Employers Portion Only	295,060	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	70,131	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,199,720	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	124,898	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-3 Part V Date/Time Prepared: 7/31/2017 3:14 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	172,579	5,199,720	1.00
2.00	Hospital	172,579	5,199,720	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet S-10 | Date/Time Prepared: 7/31/2017 3:14 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)	0.114903	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,549,358	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 or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	70,186,656	6.00
7.00	Medicaid cost (line 1 times line 6)	8,064,657	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)	515,299	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	8,866	9.00
10.00	Stand-alone CHIP charges	139,059	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	15,978	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	7,112	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
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	522,411	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	554,743	921,909	1,476,652	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	63,742	105,930	169,672	21.00
22.00	Partial payment by patients approved for charity care	10	8,075	8,085	22.00
23.00	Cost of charity care (line 21 minus line 22)	63,732	97,855	161,587	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	16,364,895	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	128,496	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	16,236,399	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,865,611	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,027,198	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,549,609	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,621,731	1,621,731	820,112	2,441,843	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,618,803	3,618,803	1,050,864	4,669,667	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	159,508	142,308	301,816	3,696,424	3,998,240	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	3,656,718	16,329,484	19,986,202	-9,278,488	10,707,714	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	4,168,448	4,168,448	5.02
7.00	00700	OPERATION OF PLANT	502,604	1,681,334	2,183,938	-49,539	2,134,399	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	296,497	296,497	0	296,497	8.00
9.00	00900	HOUSEKEEPING	504,093	290,007	794,100	0	794,100	9.00
10.00	01000	DIETARY	560,547	522,174	1,082,721	-853,986	228,735	10.00
11.00	01100	CAFETERIA	0	0	0	853,392	853,392	11.00
13.00	01300	NURSING ADMINISTRATION	1,108,366	139,396	1,247,762	168,123	1,415,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	226,693	2,713,615	2,940,308	-2,380,925	559,383	14.00
15.00	01500	PHARMACY	831,730	6,755,876	7,587,606	-6,315,067	1,272,539	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	250,854	613,397	864,251	-1,679	862,572	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,630,907	2,086,185	5,717,092	-626,621	5,090,471	30.00
31.00	03100	INTENSIVE CARE UNIT	1,043,121	179,453	1,222,574	-2,842	1,219,732	31.00
43.00	04300	NURSERY	0	0	0	186,713	186,713	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,243,438	1,193,154	2,436,592	-15,494	2,421,098	50.00
51.00	05100	RECOVERY ROOM	636,202	134,997	771,199	-979	770,220	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	434,942	434,942	52.00
53.00	05300	ANESTHESIOLOGY	0	876,675	876,675	-15,778	860,897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,020	3,107,665	5,151,685	-2,810,048	2,341,637	54.00
54.01	05401	ULTRASOUND	352,328	177,850	530,178	-530,178	0	54.01
54.02	05402	ONCOLOGY	0	0	0	2,661,696	2,661,696	54.02
56.00	05600	RADIOISOTOPE	148,786	189,586	338,372	0	338,372	56.00
57.00	05700	CT SCAN	244,648	210,398	455,046	-44,403	410,643	57.00
58.00	05800	MRI	201,263	61,215	262,478	0	262,478	58.00
60.00	06000	LABORATORY	1,423,880	1,848,339	3,272,219	-193,099	3,079,120	60.00
65.00	06500	RESPIRATORY THERAPY	398,269	58,625	456,894	130,397	587,291	65.00
66.00	06600	PHYSICAL THERAPY	700,993	1,274,213	1,975,206	-2,458	1,972,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,459	178,262	205,721	-659	205,062	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,707	20,707	0	20,707	68.00
69.00	06900	ELECTROCARDIOLOGY	178,548	17,562	196,110	0	196,110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	449,686	449,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,892,114	1,892,114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,188,845	6,188,845	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	82,448	50,606	133,054	-133,054	0	76.01
76.03	03951	WOUND CARE	87,098	76,845	163,943	-163,943	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	437,060	-121,039	316,021	160,426	476,447	90.00
91.00	09100	EMERGENCY	1,377,935	1,335,553	2,713,488	-50,095	2,663,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,059,516	47,681,473	69,740,989	-607,153	69,133,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,971	21,063	55,034	-851	54,183	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-3,107	-3,107	3,107	0	192.00
192.01	19201	WELLNESS CENTER	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	604,897	604,897	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	22,093,487	47,699,429	69,792,916	0	69,792,916	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,649,342	5,091,185		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-374,413	4,295,254		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,599	3,996,641		4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	46,715	10,754,429		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,546,789	2,621,659		5.02
7.00	00700	OPERATION OF PLANT	0	2,134,399		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-19,849	276,648		8.00
9.00	00900	HOUSEKEEPING	0	794,100		9.00
10.00	01000	DIETARY	0	228,735		10.00
11.00	01100	CAFETERIA	-256,081	597,311		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,415,885		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	559,383		14.00
15.00	01500	PHARMACY	0	1,272,539		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-29,913	832,659		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,500,386	3,590,085		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,219,732		31.00
43.00	04300	NURSERY	0	186,713		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,421,098		50.00
51.00	05100	RECOVERY ROOM	0	770,220		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	434,942		52.00
53.00	05300	ANESTHESIOLOGY	-860,897	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,914	2,339,723		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	05402	ONCOLOGY	-1,050,038	1,611,658		54.02
56.00	05600	RADIOISOTOPE	-60	338,312		56.00
57.00	05700	CT SCAN	-9,404	401,239		57.00
58.00	05800	MRI	-19,155	243,323		58.00
60.00	06000	LABORATORY	0	3,079,120		60.00
65.00	06500	RESPIRATORY THERAPY	0	587,291		65.00
66.00	06600	PHYSICAL THERAPY	0	1,972,748		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,062		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,707		68.00
69.00	06900	ELECTROCARDIOLOGY	0	196,110		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	449,686		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,892,114		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,188,845		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	476,447		90.00
91.00	09100	EMERGENCY	-824,297	1,839,096		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,798,738	65,335,098		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,183		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	93,785	93,785		192.00
192.01	19201	WELLNESS CENTER	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	604,897		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-3,704,953	66,087,963		200.00

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-6 | Date/Time Prepared: 7/31/2017 3:14 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,697,790	1.00
	0		0	3,697,790	
	B - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,224	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	26,224	
	C - LEASE AND RENTAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	199,993	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,034,094	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	1,234,087	
	D - OTHER CAPITAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	74,970	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	545,149	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,770	3.00
	0		0	636,889	
	E - MARKETING				
1.00	MARKETING	194.01	144,966	459,931	1.00
	0		144,966	459,931	
	F - CNO COST				
1.00	NURSING ADMINISTRATION	13.00	170,464	0	1.00
	0		170,464	0	
	G - CHARGABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	423,462	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,892,114	2.00
	0		0	2,315,576	
	H - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,188,845	1.00
	0		0	6,188,845	
	I - LABOR AND DELIVERY				
1.00	NURSERY	43.00	158,461	28,252	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	369,131	65,811	2.00
	0		527,592	94,063	
	J - MISC DEPARTMENTS				
1.00	CLINIC	90.00	87,098	76,845	1.00
2.00	RESPIRATORY THERAPY	65.00	82,448	47,949	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	1,392,562	2,775,886	3.00
	0		1,562,108	2,900,680	
	K - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	352,328	177,850	1.00
2.00	ONCOLOGY	54.02	792,740	1,868,956	2.00
	0		1,145,068	2,046,806	
	L - DIETARY				
1.00	CAFETERIA	11.00	442,061	411,331	1.00
	0		442,061	411,331	
	M - MOB UTILITIES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,107	1.00
	0		0	3,107	
500.00	Grand Total: Increases		3,992,259	20,015,329	500.00

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-6 | Date/Time Prepared: 7/31/2017 3:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,697,790	0		1.00
	0		0	3,697,790			
	B - OXYGEN						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,316	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	15,778	0		2.00
3.00	LABORATORY	60.00	0	130	0		3.00
	0		0	26,224			
	C - LEASE AND RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,366	10		1.00
2.00		0.00	0	0	10		2.00
3.00	OPERATION OF PLANT	7.00	0	46,432	0		3.00
4.00	DIETARY	10.00	0	594	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,341	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	63,267	0		6.00
7.00	PHARMACY	15.00	0	126,222	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,679	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	4,966	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,842	0		10.00
11.00	OPERATING ROOM	50.00	0	7,260	0		11.00
12.00	RECOVERY ROOM	51.00	0	979	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	678,530	0		13.00
14.00	CT SCAN	57.00	0	44,403	0		14.00
16.00	LABORATORY	60.00	0	192,969	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,458	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	659	0		18.00
19.00	SLEEP LAB	76.01	0	2,657	0		19.00
20.00	CLINIC	90.00	0	3,517	0		20.00
21.00	EMERGENCY	91.00	0	50,095	0		21.00
22.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	851	0		22.00
	0		0	1,234,087			
	D - OTHER CAPITAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	636,889	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	636,889			
	E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	144,966	459,931	0		1.00
	0		144,966	459,931			
	F - CNO COST						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	170,464	0	0		1.00
	0		170,464	0			
	G - CHARGABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,307,342	0		1.00
2.00	OPERATING ROOM	50.00	0	8,234	0		2.00
	0		0	2,315,576			
	H - DRUGS						
1.00	PHARMACY	15.00	0	6,188,845	0		1.00
	0		0	6,188,845			
	I - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	527,592	94,063	0		1.00
2.00		0.00	0	0	0		2.00
	0		527,592	94,063			
	J - MISC DEPARTMENTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	1,392,562	2,775,886	0		1.00
2.00	WOUND CARE	76.03	87,098	76,845	0		2.00
3.00	SLEEP LAB	76.01	82,448	47,949	0		3.00
	0		1,562,108	2,900,680			
	K - RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	792,740	1,868,956	0		1.00
2.00	ULTRASOUND	54.01	352,328	177,850	0		2.00
	0		1,145,068	2,046,806			
	L - DIETARY						
1.00	DIETARY	10.00	442,061	411,331	0		1.00
	0		442,061	411,331			

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-6 | Date/Time Prepared: 7/31/2017 3:14 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - MOB UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	3,107	0		1.00
	0		0	3,107			
500.00	Grand Total: Decreases		3,992,259	20,015,329			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-7 Part I | Date/Time Prepared: 7/31/2017 3:14 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	158,709	0	0	0	0	1.00
2.00	Land Improvements	1,539,273	0	0	0	0	2.00
3.00	Buildings and Fixtures	55,087,239	130,397	0	130,397	0	3.00
4.00	Building Improvements	161,933	0	0	0	0	4.00
5.00	Fixed Equipment	4,147,798	0	0	0	18,195	5.00
6.00	Movable Equipment	36,088,532	6,313,469	0	6,313,469	310,283	6.00
7.00	HIT designated Assets	2,274,322	0	0	0	1,619	7.00
8.00	Subtotal (sum of lines 1-7)	99,457,806	6,443,866	0	6,443,866	330,097	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	99,457,806	6,443,866	0	6,443,866	330,097	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	158,709	0	1.00
2.00	Land Improvements	1,539,273	0	2.00
3.00	Buildings and Fixtures	55,217,636	0	3.00
4.00	Building Improvements	161,933	0	4.00
5.00	Fixed Equipment	4,129,603	0	5.00
6.00	Movable Equipment	42,091,718	0	6.00
7.00	HIT designated Assets	2,272,703	0	7.00
8.00	Subtotal (sum of lines 1-7)	105,571,575	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	105,571,575	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-7 Part II | Date/Time Prepared: 7/31/2017 3:14 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,621,731	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,618,803	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,240,534	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,621,731		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,618,803		2.00
3.00	Total (sum of lines 1-2)	0	5,240,534		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-7 Part III Date/Time Prepared: 7/31/2017 3:14 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	57,077,551	0	57,077,551	0.540653	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,494,024	0	48,494,024	0.459347	0	2.00
3.00	Total (sum of lines 1-2)	105,571,575	0	105,571,575	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,359,662	198,896	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,078,729	1,034,094	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,438,391	1,232,990	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,855,282	74,970	545,149	57,226	5,091,185	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,770	0	165,661	4,295,254	2.00
3.00	Total (sum of lines 1-2)	1,855,282	91,740	545,149	222,887	9,386,439	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-8 | Date/Time Prepared: 7/31/2017 3:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)	B	-816	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-18,703	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,266,151			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	1,393,790			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-256,081	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-29,913	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	737,931	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-543,753	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
34.00	RENTAL INCOME	B	-1,097	CAP REL COSTS-BLDG & FIXT	1.00	10	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-8 | Date/Time Prepared: 7/31/2017 3:14 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	
35.00	MISC INCOME	B	-28,904	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35.00
36.00			0		0.00	0	36.00
37.00	PATIENT PHONE WAGE COST	A	-6,634	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	PATIENT PHONE BENEFIT COSTS	A	-1,599	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	PATIENT PHONE EXPENSE	A	-10,364	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	39.00
40.00	PATIENT PHONE DEPRECIATION	A	-1,309	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
41.00	PATIENT TV - DEPRECIATION	A	-6,579	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	MARKETING	A	-310,291	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00	PHYSICIAN RECRUITING	A	-14,294	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	43.00
44.00	CHARITABLE CONTRIBUTIONS	A	-25,756	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00			0		0.00	0	45.00
45.01	MINORITY INTEREST	A	-311,031	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.01
45.02	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-6,547	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.02
45.03	TRANSPORTATION COSTS	A	-1,999	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.03
45.04	LEGAL FEES	A	-67,381	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.04
45.05	POB DEPRECIATION	A	93,785	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.05
45.06			0		0.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09	MEALS AND ENTERTAINMENT	A	-21,257	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,704,953				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-8-1 | Date/Time Prepared: 7/31/2017 3:14 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL-	1,855,282	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	45,754	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	7,180	0	3.00
4.00	5.01	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	680,454	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	11,472	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	158,481	0	4.05
4.06	5.01	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,907,623	0	4.06
4.07	5.01	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS (SEE EXHIB	155,306	0	4.07
4.08	5.02	OTHER ADMINISTRATIVE AND GEN	CIG LEASED EQUIPMENT (SEE EX	95,462	0	4.08
4.09	5.02	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	678,227	4.09
4.10	5.01	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	9,500	4.10
4.11	5.01	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	65,498	4.11
4.12	5.01	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1,515,251	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	5.01	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	31,200	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	5.02	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	719,136	4.21
4.22	5.02	OTHER ADMINISTRATIVE AND GEN	EBOS FEES	0	4,307	4.22
4.23	5.02	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	49,600	4.23
4.24	5.01	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS (PER	0	286,943	4.24
4.25	5.02	OTHER ADMINISTRATIVE AND GEN	CIG LEASED EQUIPMENT (PER EX	0	173,983	4.25
4.26	2.00	CAP REL COSTS-MVBLE EQUIP	LAUNDRY CAPITAL	30,270	0	4.26
4.27	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY OPERATING	276,648	296,497	4.27
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,223,932	3,830,142	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00	C		0.00	HOSPITAL LAUNDR	20.00	7.00
8.00	C		0.00	PASI	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet A-8-1 Date/Time Prepared: 7/31/2017 3:14 pm

	Related Organization(s) and/or Home Office					
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-8-1 | Date/Time Prepared: 7/31/2017 3:14 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,855,282	11		1.00
2.00	45,754	14		2.00
3.00	7,180	14		3.00
4.00	680,454	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	11,472	14		4.04
4.05	158,481	14		4.05
4.06	1,907,623	0		4.06
4.07	155,306	0		4.07
4.08	95,462	0		4.08
4.09	-678,227	0		4.09
4.10	-9,500	0		4.10
4.11	-65,498	0		4.11
4.12	-1,515,251	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	-31,200	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	-719,136	0		4.21
4.22	-4,307	0		4.22
4.23	-49,600	0		4.23
4.24	-286,943	0		4.24
4.25	-173,983	0		4.25
4.26	30,270	9		4.26
4.27	-19,849	0		4.27
5.00	1,393,790			5.00

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

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

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	LAUNDRY SERVICES		7.00
8.00	DEBT COLLECTION		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet A-8-2 | Date/Time Prepared: 7/31/2017 3:14 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	1,500,386	1,500,386	0	0	0	1.00
2.00	91.00	EMERGENCY	824,297	824,297	0	0	0	2.00
3.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	860,897	860,897	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,914	1,914	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	54.02	ONCOLOGY	1,050,038	1,050,038	0	0	0	8.00
9.00	57.00	CT SCAN	9,404	9,404	0	0	0	9.00
10.00	58.00	MRI	19,155	19,155	0	0	0	10.00
11.00	56.00	RADIOISOTOPE	60	60	0	0	0	11.00
200.00			4,266,151	4,266,151	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	54.02	ONCOLOGY	0	0	0	0	0	8.00
9.00	57.00	CT SCAN	0	0	0	0	0	9.00
10.00	58.00	MRI	0	0	0	0	0	10.00
11.00	56.00	RADIOISOTOPE	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,500,386		1.00
2.00	91.00	EMERGENCY	0	0	0	824,297		2.00
3.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	860,897		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,914		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	90.00	CLINIC	0	0	0	0		7.00
8.00	54.02	ONCOLOGY	0	0	0	1,050,038		8.00
9.00	57.00	CT SCAN	0	0	0	9,404		9.00
10.00	58.00	MRI	0	0	0	19,155		10.00
11.00	56.00	RADIOISOTOPE	0	0	0	60		11.00
200.00			0	0	0	4,266,151		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part I | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,091,185	5,091,185				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,295,254		4,295,254			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,996,641	12,563	10,599	4,019,803		4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	10,754,429	234,786	198,081	357,139	11,544,435	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	2,621,659	379,125	319,854	255,212	3,575,850	5.02
7.00	00700	OPERATION OF PLANT	2,134,399	374,461	315,919	92,111	2,916,890	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276,648	7,795	6,576	0	291,019	8.00
9.00	00900	HOUSEKEEPING	794,100	16,448	13,876	92,384	916,808	9.00
10.00	01000	DIETARY	228,735	45,185	38,121	21,715	333,756	10.00
11.00	01100	CAFETERIA	597,311	37,962	32,027	81,016	748,316	11.00
13.00	01300	NURSING ADMINISTRATION	1,415,885	9,835	8,297	234,369	1,668,386	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	559,383	26,113	22,031	41,546	649,073	14.00
15.00	01500	PHARMACY	1,272,539	25,672	21,658	152,429	1,472,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	832,659	35,987	30,361	45,974	944,981	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,590,085	546,406	460,984	568,744	5,166,219	30.00
31.00	03100	INTENSIVE CARE UNIT	1,219,732	122,135	103,041	191,171	1,636,079	31.00
43.00	04300	NURSERY	186,713	11,693	9,865	29,041	237,312	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,421,098	227,420	191,866	227,882	3,068,266	50.00
51.00	05100	RECOVERY ROOM	770,220	10,718	9,043	116,595	906,576	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,942	44,718	37,727	67,650	585,037	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,339,723	169,386	142,905	293,890	2,945,904	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	1,611,658	145,637	122,869	145,284	2,025,448	54.02
56.00	05600	RADIOISOTOPE	338,312	6,639	5,601	27,268	377,820	56.00
57.00	05700	CT SCAN	401,239	32,830	27,698	44,836	506,603	57.00
58.00	05800	MRI	243,323	43,548	36,740	36,885	360,496	58.00
60.00	06000	LABORATORY	3,079,120	79,185	66,805	260,952	3,486,062	60.00
65.00	06500	RESPIRATORY THERAPY	587,291	39,274	33,134	88,100	747,799	65.00
66.00	06600	PHYSICAL THERAPY	1,972,748	124,409	104,959	128,470	2,330,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,062	0	0	5,032	210,094	67.00
68.00	06800	SPEECH PATHOLOGY	20,707	1,299	1,096	0	23,102	68.00
69.00	06900	ELECTROCARDIOLOGY	196,110	650	548	32,722	230,030	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	449,686	0	0	0	449,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,892,114	0	0	0	1,892,114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,188,845	0	0	0	6,188,845	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	476,447	49,472	41,738	96,061	663,718	90.00
91.00	09100	EMERGENCY	1,839,096	174,089	146,873	252,531	2,412,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,335,098	3,035,440	2,560,892	3,987,009	61,512,197	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54,183	7,990	6,741	6,226	75,140	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	93,785	1,700,395	1,434,566	0	3,228,746	192.00
192.01	19201	WELLNESS CENTER	0	153,211	129,259	0	282,470	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	604,897	27,166	22,919	26,568	681,550	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	166,983	140,877	0	307,860	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	66,087,963	5,091,185	4,295,254	4,019,803	66,087,963	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part I | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	11,544,435					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	756,847	4,332,697	4,332,697			5.02
7.00	00700	OPERATION OF PLANT	617,374	3,534,264	264,731	3,798,995		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,596	352,615	26,412	7,240	386,267	8.00
9.00	00900	HOUSEKEEPING	194,047	1,110,855	83,207	15,276	0	9.00
10.00	01000	DIETARY	70,641	404,397	30,291	41,968	0	10.00
11.00	01100	CAFETERIA	158,385	906,701	67,916	35,259	0	11.00
13.00	01300	NURSING ADMINISTRATION	353,122	2,021,508	151,419	9,134	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	137,380	786,453	58,908	24,254	13,169	14.00
15.00	01500	PHARMACY	311,619	1,783,917	133,623	23,844	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	200,010	1,144,991	85,764	33,425	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,093,456	6,259,675	468,875	507,498	85,602	30.00
31.00	03100	INTENSIVE CARE UNIT	346,284	1,982,363	148,487	113,438	23,046	31.00
43.00	04300	NURSERY	50,228	287,540	21,538	10,860	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	649,414	3,717,680	278,469	211,226	83,955	50.00
51.00	05100	RECOVERY ROOM	191,881	1,098,457	82,279	9,955	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	123,826	708,863	53,097	41,533	39,508	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,515	3,569,419	267,364	157,325	42,072	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	428,696	2,454,144	183,825	135,267	0	54.02
56.00	05600	RADIOISOTOPE	79,967	457,787	34,290	6,166	0	56.00
57.00	05700	CT SCAN	107,225	613,828	45,978	30,492	0	57.00
58.00	05800	MRI	76,301	436,797	32,718	40,447	0	58.00
60.00	06000	LABORATORY	737,842	4,223,904	316,387	73,546	0	60.00
65.00	06500	RESPIRATORY THERAPY	158,275	906,074	67,869	36,477	0	65.00
66.00	06600	PHYSICAL THERAPY	493,280	2,823,866	211,519	115,550	25,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,467	254,561	19,068	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,890	27,992	2,097	1,207	0	68.00
69.00	06900	ELECTROCARDIOLOGY	48,687	278,717	20,877	603	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	95,178	544,864	40,812	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	400,475	2,292,589	171,724	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,928	7,498,773	561,701	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,479	804,197	60,238	45,950	6,585	90.00
91.00	09100	EMERGENCY	510,637	2,923,226	218,961	161,693	46,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,575,952	60,543,714	4,210,444	1,889,633	365,944	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,904	91,044	6,820	7,421	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	683,380	3,912,126	0	1,579,316	0	192.00
192.01	19201	WELLNESS CENTER	59,786	342,256	25,636	142,302	20,323	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	144,253	825,803	61,856	25,231	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	65,160	373,020	27,941	155,092	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,544,435	66,087,963	4,332,697	3,798,995	386,267	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part I | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,209,338					9.00
10.00	01000	DIETARY	14,044	490,700				10.00
11.00	01100	CAFETERIA	11,799	0	1,021,675			11.00
13.00	01300	NURSING ADMINISTRATION	3,057	0	62,035	2,247,153		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,116	0	22,837	0	913,737	14.00
15.00	01500	PHARMACY	7,979	0	30,684	0	28,450	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,185	0	24,974	0	1,221	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	169,824	262,358	173,051	525,371	48,029	30.00
31.00	03100	INTENSIVE CARE UNIT	37,960	47,869	57,327	203,630	16,108	31.00
43.00	04300	NURSERY	3,634	0	14,223	61,197	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,682	7,637	64,673	242,734	185,155	50.00
51.00	05100	RECOVERY ROOM	3,331	0	32,854	124,194	11,649	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,898	53,169	28,413	122,223	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,645	0	103,136	313,044	15,390	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	45,264	0	39,331	154,752	8,478	54.02
56.00	05600	RADIOISOTOPE	2,063	0	6,678	0	2,913	56.00
57.00	05700	CT SCAN	10,204	0	14,290	0	11,279	57.00
58.00	05800	MRI	13,535	0	10,350	0	1,191	58.00
60.00	06000	LABORATORY	24,611	0	109,146	0	89,632	60.00
65.00	06500	RESPIRATORY THERAPY	12,206	0	30,350	93,842	6,670	65.00
66.00	06600	PHYSICAL THERAPY	38,666	0	57,494	0	6,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,472	0	1,121	67.00
68.00	06800	SPEECH PATHOLOGY	404	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	202	0	14,357	34,855	386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	62,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	349,536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,376	0	35,492	102,322	22,534	90.00
91.00	09100	EMERGENCY	54,107	0	74,088	268,989	40,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	624,792	371,033	1,009,255	2,247,153	909,052	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,105	0	2,722	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	528,485	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	47,618	73,274	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	8,443	46,393	9,315	0	1,963	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,209,338	490,700	1,021,675	2,247,153	913,737	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part I | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	2,008,497					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,301,560				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	114,891	8,615,174	0	8,615,174	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,636	2,639,864	0	2,639,864	31.00
43.00	04300	NURSERY	0	3,161	402,153	0	402,153	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	154,253	5,016,464	0	5,016,464	50.00
51.00	05100	RECOVERY ROOM	0	13,570	1,376,289	0	1,376,289	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,362	1,068,066	0	1,068,066	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,345	4,561,740	0	4,561,740	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	32,860	3,053,921	0	3,053,921	54.02
56.00	05600	RADIOISOTOPE	0	18,178	528,075	0	528,075	56.00
57.00	05700	CT SCAN	0	115,478	841,549	0	841,549	57.00
58.00	05800	MRI	0	32,295	567,333	0	567,333	58.00
60.00	06000	LABORATORY	0	141,929	4,979,155	0	4,979,155	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,437	1,185,925	0	1,185,925	65.00
66.00	06600	PHYSICAL THERAPY	0	18,647	3,298,098	0	3,298,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,743	280,965	0	280,965	67.00
68.00	06800	SPEECH PATHOLOGY	0	390	32,090	0	32,090	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,873	367,870	0	367,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,447	687,496	0	687,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,300	2,854,149	0	2,854,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,008,497	376,149	10,445,120	0	10,445,120	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	12,675	1,105,369	0	1,105,369	90.00
91.00	09100	EMERGENCY	0	75,941	3,863,593	0	3,863,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,008,497	1,301,560	57,770,458	0	57,770,458	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	111,112	0	111,112	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,019,927	0	6,019,927	192.00
192.01	19201	WELLNESS CENTER	0	0	651,409	0	651,409	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	979,004	0	979,004	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	556,053	0	556,053	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,008,497	1,301,560	66,087,963	0	66,087,963	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part II | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,563	10,599	23,162	23,162	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	0	234,786	198,081	432,867	2,058	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	379,125	319,854	698,979	1,471	5.02
7.00	00700	OPERATION OF PLANT	0	374,461	315,919	690,380	531	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,795	6,576	14,371	0	8.00
9.00	00900	HOUSEKEEPING	0	16,448	13,876	30,324	532	9.00
10.00	01000	DIETARY	0	45,185	38,121	83,306	125	10.00
11.00	01100	CAFETERIA	0	37,962	32,027	69,989	467	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,835	8,297	18,132	1,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,113	22,031	48,144	239	14.00
15.00	01500	PHARMACY	0	25,672	21,658	47,330	878	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,987	30,361	66,348	265	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	546,406	460,984	1,007,390	3,276	30.00
31.00	03100	INTENSIVE CARE UNIT	0	122,135	103,041	225,176	1,102	31.00
43.00	04300	NURSERY	0	11,693	9,865	21,558	167	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	227,420	191,866	419,286	1,313	50.00
51.00	05100	RECOVERY ROOM	0	10,718	9,043	19,761	672	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,718	37,727	82,445	390	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	169,386	142,905	312,291	1,693	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	145,637	122,869	268,506	837	54.02
56.00	05600	RADIOISOTOPE	0	6,639	5,601	12,240	157	56.00
57.00	05700	CT SCAN	0	32,830	27,698	60,528	258	57.00
58.00	05800	MRI	0	43,548	36,740	80,288	213	58.00
60.00	06000	LABORATORY	0	79,185	66,805	145,990	1,504	60.00
65.00	06500	RESPIRATORY THERAPY	0	39,274	33,134	72,408	508	65.00
66.00	06600	PHYSICAL THERAPY	0	124,409	104,959	229,368	740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	29	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,299	1,096	2,395	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	650	548	1,198	189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	49,472	41,738	91,210	554	90.00
91.00	09100	EMERGENCY	0	174,089	146,873	320,962	1,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,035,440	2,560,892	5,596,332	22,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,990	6,741	14,731	36	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,700,395	1,434,566	3,134,961	0	192.00
192.01	19201	WELLNESS CENTER	0	153,211	129,259	282,470	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	27,166	22,919	50,085	153	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	166,983	140,877	307,860	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	5,091,185	4,295,254	9,386,439	23,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part II | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	434,925					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	28,514	728,964				5.02
7.00	00700	OPERATION OF PLANT	23,259	44,539	758,709			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,321	4,444	1,446	22,582		8.00
9.00	00900	HOUSEKEEPING	7,311	13,999	3,051	0	55,217	9.00
10.00	01000	DIETARY	2,661	5,096	8,382	0	641	10.00
11.00	01100	CAFETERIA	5,967	11,426	7,042	0	539	11.00
13.00	01300	NURSING ADMINISTRATION	13,304	25,475	1,824	0	140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,176	9,911	4,844	770	371	14.00
15.00	01500	PHARMACY	11,740	22,481	4,762	0	364	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,535	14,429	6,675	0	511	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,195	78,884	101,354	5,004	7,754	30.00
31.00	03100	INTENSIVE CARE UNIT	13,046	24,982	22,655	1,347	1,733	31.00
43.00	04300	NURSERY	1,892	3,624	2,169	0	166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,466	46,850	42,185	4,908	3,227	50.00
51.00	05100	RECOVERY ROOM	7,229	13,843	1,988	0	152	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,665	8,933	8,295	2,310	635	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,491	44,982	31,420	2,460	2,404	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	16,151	30,927	27,015	0	2,067	54.02
56.00	05600	RADIOISOTOPE	3,013	5,769	1,231	0	94	56.00
57.00	05700	CT SCAN	4,040	7,735	6,090	0	466	57.00
58.00	05800	MRI	2,875	5,505	8,078	0	618	58.00
60.00	06000	LABORATORY	27,798	53,230	14,688	0	1,124	60.00
65.00	06500	RESPIRATORY THERAPY	5,963	11,418	7,285	0	557	65.00
66.00	06600	PHYSICAL THERAPY	18,584	35,586	23,077	1,515	1,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,675	3,208	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	184	353	241	0	18	68.00
69.00	06900	ELECTROCARDIOLOGY	1,834	3,512	120	0	9	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,586	6,866	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,088	28,891	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,345	94,526	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,292	10,134	9,177	385	702	90.00
91.00	09100	EMERGENCY	19,238	36,838	32,292	2,695	2,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,438	708,396	377,386	21,394	28,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	599	1,147	1,482	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,746	0	315,408	0	24,130	192.00
192.01	19201	WELLNESS CENTER	2,252	4,313	28,420	1,188	2,174	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,435	10,407	5,039	0	386	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	2,455	4,701	30,974	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	434,925	728,964	758,709	22,582	55,217	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part II | Date/Time Prepared: 7/31/2017 3:14 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	100,211					10.00
11.00	01100	CAFETERIA	0	95,430				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,794	66,019			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,133	0	71,588		14.00
15.00	01500	PHARMACY	0	2,866	0	2,229	92,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,333	0	96	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,579	16,163	15,436	3,763	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,776	5,355	5,982	1,262	0	31.00
43.00	04300	NURSERY	0	1,329	1,798	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,560	6,041	7,131	14,507	0	50.00
51.00	05100	RECOVERY ROOM	0	3,069	3,649	913	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,858	2,654	3,591	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,633	9,197	1,206	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	3,674	4,546	664	0	54.02
56.00	05600	RADIOISOTOPE	0	624	0	228	0	56.00
57.00	05700	CT SCAN	0	1,335	0	884	0	57.00
58.00	05800	MRI	0	967	0	93	0	58.00
60.00	06000	LABORATORY	0	10,195	0	7,023	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,835	2,757	523	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,370	0	505	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	324	0	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,341	1,024	30	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,887	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,382	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	92,650	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,315	3,006	1,765	0	90.00
91.00	09100	EMERGENCY	0	6,920	7,902	3,173	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,773	94,270	66,019	71,221	92,650	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	290	0	213	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	14,964	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	9,474	870	0	154	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	100,211	95,430	66,019	71,588	92,650	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B Part II | Date/Time Prepared: 7/31/2017 3:14 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	98,192					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,653	1,342,451	0	1,342,451		30.00
31.00	03100	INTENSIVE CARE UNIT	726	313,142	0	313,142		31.00
43.00	04300	NURSERY	238	32,941	0	32,941		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,618	583,092	0	583,092		50.00
51.00	05100	RECOVERY ROOM	1,022	52,298	0	52,298		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	555	125,331	0	125,331		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,114	441,891	0	441,891		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
54.02	05402	ONCOLOGY	2,475	356,862	0	356,862		54.02
56.00	05600	RADIOISOTOPE	1,369	24,725	0	24,725		56.00
57.00	05700	CT SCAN	8,698	90,034	0	90,034		57.00
58.00	05800	MRI	2,432	101,069	0	101,069		58.00
60.00	06000	LABORATORY	10,690	272,242	0	272,242		60.00
65.00	06500	RESPIRATORY THERAPY	2,443	106,697	0	106,697		65.00
66.00	06600	PHYSICAL THERAPY	1,404	317,914	0	317,914		66.00
67.00	06700	OCCUPATIONAL THERAPY	207	5,531	0	5,531		67.00
68.00	06800	SPEECH PATHOLOGY	29	3,220	0	3,220		68.00
69.00	06900	ELECTROCARDIOLOGY	1,346	10,603	0	10,603		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,971	18,310	0	18,310		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,035	74,396	0	74,396		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,492	265,013	0	265,013		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	955	126,495	0	126,495		90.00
91.00	09100	EMERGENCY	5,720	439,665	0	439,665		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,192	5,103,922	0	5,103,922		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,498	0	18,498		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,500,245	0	3,500,245		192.00
192.01	19201	WELLNESS CENTER	0	335,781	0	335,781		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	82,003	0	82,003		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	345,990	0	345,990		194.03
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 118-201)	98,192	9,386,439	0	9,386,439		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B-1 | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	391,879					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		391,879				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	967	967	21,933,979			4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	18,072	18,072	1,948,726	-11,544,435	54,543,528	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	29,182	29,182	1,392,562	0	3,575,850	5.02
7.00	00700	OPERATION OF PLANT	28,823	28,823	502,604	0	2,916,890	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	600	600	0	0	291,019	8.00
9.00	00900	HOUSEKEEPING	1,266	1,266	504,093	0	916,808	9.00
10.00	01000	DIETARY	3,478	3,478	118,486	0	333,756	10.00
11.00	01100	CAFETERIA	2,922	2,922	442,061	0	748,316	11.00
13.00	01300	NURSING ADMINISTRATION	757	757	1,278,830	0	1,668,386	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,010	2,010	226,693	0	649,073	14.00
15.00	01500	PHARMACY	1,976	1,976	831,730	0	1,472,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	2,770	250,854	0	944,981	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,058	42,058	3,103,315	0	5,166,219	30.00
31.00	03100	INTENSIVE CARE UNIT	9,401	9,401	1,043,121	0	1,636,079	31.00
43.00	04300	NURSERY	900	900	158,461	0	237,312	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,505	17,505	1,243,438	0	3,068,266	50.00
51.00	05100	RECOVERY ROOM	825	825	636,202	0	906,576	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,442	3,442	369,131	0	585,037	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,038	13,038	1,603,608	0	2,945,904	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	11,210	11,210	792,740	0	2,025,448	54.02
56.00	05600	RADIOISOTOPE	511	511	148,786	0	377,820	56.00
57.00	05700	CT SCAN	2,527	2,527	244,648	0	506,603	57.00
58.00	05800	MRI	3,352	3,352	201,263	0	360,496	58.00
60.00	06000	LABORATORY	6,095	6,095	1,423,880	0	3,486,062	60.00
65.00	06500	RESPIRATORY THERAPY	3,023	3,023	480,717	0	747,799	65.00
66.00	06600	PHYSICAL THERAPY	9,576	9,576	700,993	0	2,330,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	27,459	0	210,094	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	0	0	23,102	68.00
69.00	06900	ELECTROCARDIOLOGY	50	50	178,548	0	230,030	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	449,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,892,114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,188,845	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,808	3,808	524,158	0	663,718	90.00
91.00	09100	EMERGENCY	13,400	13,400	1,377,935	0	2,412,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	233,644	233,644	21,755,042	-11,544,435	49,967,762	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	33,971	0	75,140	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	130,883	130,883	0	0	3,228,746	192.00
192.01	19201	WELLNESS CENTER	11,793	11,793	0	0	282,470	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,091	2,091	144,966	0	681,550	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	12,853	12,853	0	0	307,860	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,091,185	4,295,254	4,019,803		11,544,435	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.991727	10.960664	0.183268		0.211655	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,162		434,925	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001056		0.007974	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B-1 | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-4,332,697	57,843,140				5.02
7.00	00700	OPERATION OF PLANT	0	3,534,264	314,835			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	352,615	600	486,456		8.00
9.00	00900	HOUSEKEEPING	0	1,110,855	1,266	0	299,501	9.00
10.00	01000	DIETARY	0	404,397	3,478	0	3,478	10.00
11.00	01100	CAFETERIA	0	906,701	2,922	0	2,922	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,021,508	757	0	757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	786,453	2,010	16,585	2,010	14.00
15.00	01500	PHARMACY	0	1,783,917	1,976	0	1,976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,144,991	2,770	0	2,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,259,675	42,058	107,805	42,058	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,982,363	9,401	29,024	9,401	31.00
43.00	04300	NURSERY	0	287,540	900	0	900	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,717,680	17,505	105,731	17,505	50.00
51.00	05100	RECOVERY ROOM	0	1,098,457	825	0	825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	708,863	3,442	49,756	3,442	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,569,419	13,038	52,984	13,038	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	2,454,144	11,210	0	11,210	54.02
56.00	05600	RADIOISOTOPE	0	457,787	511	0	511	56.00
57.00	05700	CT SCAN	0	613,828	2,527	0	2,527	57.00
58.00	05800	MRI	0	436,797	3,352	0	3,352	58.00
60.00	06000	LABORATORY	0	4,223,904	6,095	0	6,095	60.00
65.00	06500	RESPIRATORY THERAPY	0	906,074	3,023	0	3,023	65.00
66.00	06600	PHYSICAL THERAPY	0	2,823,866	9,576	32,635	9,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	254,561	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,992	100	0	100	68.00
69.00	06900	ELECTROCARDIOLOGY	0	278,717	50	0	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	544,864	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,292,589	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,498,773	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	804,197	3,808	8,293	3,808	90.00
91.00	09100	EMERGENCY	0	2,923,226	13,400	58,049	13,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,332,697	56,211,017	156,600	460,862	154,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	91,044	615	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-3,912,126	0	130,883	0	130,883	192.00
192.01	19201	WELLNESS CENTER	0	342,256	11,793	25,594	11,793	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	825,803	2,091	0	2,091	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	373,020	12,853	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		4,332,697	3,798,995	386,267	1,209,338	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.074904	12.066622	0.794043	4.037843	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		728,964	758,709	22,582	55,217	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.012602	2.409862	0.046421	0.184363	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B-1 | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	87,768					10.00
11.00	01100	CAFETERIA	0	30,600				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,858	11,511,374			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	684	0	5,136,666		14.00
15.00	01500	PHARMACY	0	919	0	159,932	6,188,845	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	748	0	6,866	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,926	5,183	2,691,312	270,001	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,562	1,717	1,043,121	90,554	0	31.00
43.00	04300	NURSERY	0	426	313,491	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,366	1,937	1,243,438	1,040,869	0	50.00
51.00	05100	RECOVERY ROOM	0	984	636,202	65,484	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,510	851	626,104	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,089	1,603,608	86,518	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	1,178	792,740	47,661	0	54.02
56.00	05600	RADIOISOTOPE	0	200	0	16,375	0	56.00
57.00	05700	CT SCAN	0	428	0	63,408	0	57.00
58.00	05800	MRI	0	310	0	6,698	0	58.00
60.00	06000	LABORATORY	0	3,269	0	503,877	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	909	480,717	37,497	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,722	0	36,216	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104	0	6,300	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	430	178,548	2,170	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	350,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,964,941	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,188,845	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,063	524,158	126,675	0	90.00
91.00	09100	EMERGENCY	0	2,219	1,377,935	227,649	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,364	30,228	11,511,374	5,110,326	6,188,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	93	0	15,303	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	13,106	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	8,298	279	0	11,037	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	490,700	1,021,675	2,247,153	913,737	2,008,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.590876	33.388072	0.195212	0.177885	0.324535	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,211	95,430	66,019	71,588	92,650	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.141771	3.118627	0.005735	0.013937	0.014970	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet B-1 | Date/Time Prepared: 7/31/2017 3:14 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)					
			16.00					
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	502,776,811					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,376,402					30.00
31.00	03100	INTENSIVE CARE UNIT	3,721,898					31.00
43.00	04300	NURSERY	1,220,749					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,580,121					50.00
51.00	05100	RECOVERY ROOM	5,241,580					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,843,710					52.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,969,502					54.00
54.01	05401	ULTRASOUND	0					54.01
54.02	05402	ONCOLOGY	12,691,991					54.02
56.00	05600	RADIOISOTOPE	7,021,252					56.00
57.00	05700	CT SCAN	44,603,413					57.00
58.00	05800	MRI	12,474,059					58.00
60.00	06000	LABORATORY	54,819,884					60.00
65.00	06500	RESPIRATORY THERAPY	12,528,768					65.00
66.00	06600	PHYSICAL THERAPY	7,202,524					66.00
67.00	06700	OCCUPATIONAL THERAPY	1,059,409					67.00
68.00	06800	SPEECH PATHOLOGY	150,740					68.00
69.00	06900	ELECTROCARDIOLOGY	6,903,251					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,236,402					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,565,732					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,337,457					73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0					76.00
76.01	03610	SLEEP LAB	0					76.01
76.03	03951	WOUND CARE	0					76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,895,688					90.00
91.00	09100	EMERGENCY	29,332,279					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	502,776,811					118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
192.01	19201	WELLNESS CENTER	0					192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0					194.00
194.01	07951	MARKETING	0					194.01
194.02	07952	SENIOR CIRCLE	0					194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0					194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,301,560					202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002589					203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,192					204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000195					205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,615,174		8,615,174	0	8,615,174	30.00
31.00	03100	INTENSIVE CARE UNIT	2,639,864		2,639,864	0	2,639,864	31.00
43.00	04300	NURSERY	402,153		402,153	0	402,153	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,016,464		5,016,464	0	5,016,464	50.00
51.00	05100	RECOVERY ROOM	1,376,289		1,376,289	0	1,376,289	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,068,066		1,068,066	0	1,068,066	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,561,740		4,561,740	0	4,561,740	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	3,053,921		3,053,921	0	3,053,921	54.02
56.00	05600	RADIOISOTOPE	528,075		528,075	0	528,075	56.00
57.00	05700	CT SCAN	841,549		841,549	0	841,549	57.00
58.00	05800	MRI	567,333		567,333	0	567,333	58.00
60.00	06000	LABORATORY	4,979,155		4,979,155	0	4,979,155	60.00
65.00	06500	RESPIRATORY THERAPY	1,185,925	0	1,185,925	0	1,185,925	65.00
66.00	06600	PHYSICAL THERAPY	3,298,098	0	3,298,098	0	3,298,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,965	0	280,965	0	280,965	67.00
68.00	06800	SPEECH PATHOLOGY	32,090	0	32,090	0	32,090	68.00
69.00	06900	ELECTROCARDIOLOGY	367,870		367,870	0	367,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	687,496		687,496	0	687,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,854,149		2,854,149	0	2,854,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,445,120		10,445,120	0	10,445,120	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,105,369		1,105,369	0	1,105,369	90.00
91.00	09100	EMERGENCY	3,863,593		3,863,593	0	3,863,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,698,860		1,698,860		1,698,860	92.00
200.00		Subtotal (see instructions)	59,469,318	0	59,469,318	0	59,469,318	200.00
201.00		Less Observation Beds	1,698,860		1,698,860		1,698,860	201.00
202.00		Total (see instructions)	57,770,458	0	57,770,458	0	57,770,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,791,618		37,791,618			30.00
31.00	03100	INTENSIVE CARE UNIT	3,721,898		3,721,898			31.00
43.00	04300	NURSERY	1,220,749		1,220,749			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,135,498	39,444,623	59,580,121	0.084197	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,747,323	3,494,257	5,241,580	0.262571	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,571,121	272,589	2,843,710	0.375589	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,752,730	14,216,772	15,969,502	0.285653	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	59,637	12,632,354	12,691,991	0.240618	0.000000	54.02
56.00	05600	RADIOISOTOPE	610,777	6,410,475	7,021,252	0.075211	0.000000	56.00
57.00	05700	CT SCAN	7,589,766	37,013,647	44,603,413	0.018867	0.000000	57.00
58.00	05800	MRI	1,053,062	11,420,997	12,474,059	0.045481	0.000000	58.00
60.00	06000	LABORATORY	14,838,289	39,981,595	54,819,884	0.090828	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,652,718	3,876,050	12,528,768	0.094656	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,202,304	6,000,220	7,202,524	0.457909	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,212	957,197	1,059,409	0.265209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	75,390	75,350	150,740	0.212883	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,827,437	5,075,814	6,903,251	0.053289	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,509,808	8,726,594	15,236,402	0.045122	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,094,724	5,471,008	15,565,732	0.183361	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,247,025	97,090,432	145,337,457	0.071868	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	583,917	4,311,771	4,895,688	0.225784	0.000000	90.00
91.00	09100	EMERGENCY	6,132,000	23,200,279	29,332,279	0.131718	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,771,674	4,813,110	6,584,784	0.257998	0.000000	92.00
200.00		Subtotal (see instructions)	178,291,677	324,485,134	502,776,811			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	178,291,677	324,485,134	502,776,811			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.084197	50.00
51.00	05100	RECOVERY ROOM	0.262571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.375589	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.285653	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.240618	54.02
56.00	05600	RADIOISOTOPE	0.075211	56.00
57.00	05700	CT SCAN	0.018867	57.00
58.00	05800	MRI	0.045481	58.00
60.00	06000	LABORATORY	0.090828	60.00
65.00	06500	RESPIRATORY THERAPY	0.094656	65.00
66.00	06600	PHYSICAL THERAPY	0.457909	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265209	67.00
68.00	06800	SPEECH PATHOLOGY	0.212883	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071868	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.225784	90.00
91.00	09100	EMERGENCY	0.131718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257998	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,615,174		8,615,174	0	8,615,174	30.00
31.00	03100	INTENSIVE CARE UNIT	2,639,864		2,639,864	0	2,639,864	31.00
43.00	04300	NURSERY	402,153		402,153	0	402,153	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,016,464		5,016,464	0	5,016,464	50.00
51.00	05100	RECOVERY ROOM	1,376,289		1,376,289	0	1,376,289	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,068,066		1,068,066	0	1,068,066	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,561,740		4,561,740	0	4,561,740	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	3,053,921		3,053,921	0	3,053,921	54.02
56.00	05600	RADIOISOTOPE	528,075		528,075	0	528,075	56.00
57.00	05700	CT SCAN	841,549		841,549	0	841,549	57.00
58.00	05800	MRI	567,333		567,333	0	567,333	58.00
60.00	06000	LABORATORY	4,979,155		4,979,155	0	4,979,155	60.00
65.00	06500	RESPIRATORY THERAPY	1,185,925	0	1,185,925	0	1,185,925	65.00
66.00	06600	PHYSICAL THERAPY	3,298,098	0	3,298,098	0	3,298,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,965	0	280,965	0	280,965	67.00
68.00	06800	SPEECH PATHOLOGY	32,090	0	32,090	0	32,090	68.00
69.00	06900	ELECTROCARDIOLOGY	367,870		367,870	0	367,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	687,496		687,496	0	687,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,854,149		2,854,149	0	2,854,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,445,120		10,445,120	0	10,445,120	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,105,369		1,105,369	0	1,105,369	90.00
91.00	09100	EMERGENCY	3,863,593		3,863,593	0	3,863,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,698,860		1,698,860		1,698,860	92.00
200.00		Subtotal (see instructions)	59,469,318	0	59,469,318	0	59,469,318	200.00
201.00		Less Observation Beds	1,698,860		1,698,860		1,698,860	201.00
202.00		Total (see instructions)	57,770,458	0	57,770,458	0	57,770,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,791,618		37,791,618			30.00
31.00	03100	INTENSIVE CARE UNIT	3,721,898		3,721,898			31.00
43.00	04300	NURSERY	1,220,749		1,220,749			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,135,498	39,444,623	59,580,121	0.084197	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,747,323	3,494,257	5,241,580	0.262571	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,571,121	272,589	2,843,710	0.375589	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,752,730	14,216,772	15,969,502	0.285653	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	59,637	12,632,354	12,691,991	0.240618	0.000000	54.02
56.00	05600	RADIOISOTOPE	610,777	6,410,475	7,021,252	0.075211	0.000000	56.00
57.00	05700	CT SCAN	7,589,766	37,013,647	44,603,413	0.018867	0.000000	57.00
58.00	05800	MRI	1,053,062	11,420,997	12,474,059	0.045481	0.000000	58.00
60.00	06000	LABORATORY	14,838,289	39,981,595	54,819,884	0.090828	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,652,718	3,876,050	12,528,768	0.094656	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,202,304	6,000,220	7,202,524	0.457909	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,212	957,197	1,059,409	0.265209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	75,390	75,350	150,740	0.212883	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,827,437	5,075,814	6,903,251	0.053289	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,509,808	8,726,594	15,236,402	0.045122	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,094,724	5,471,008	15,565,732	0.183361	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,247,025	97,090,432	145,337,457	0.071868	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	583,917	4,311,771	4,895,688	0.225784	0.000000	90.00
91.00	09100	EMERGENCY	6,132,000	23,200,279	29,332,279	0.131718	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,771,674	4,813,110	6,584,784	0.257998	0.000000	92.00
200.00		Subtotal (see instructions)	178,291,677	324,485,134	502,776,811			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	178,291,677	324,485,134	502,776,811			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.084197	50.00
51.00	05100	RECOVERY ROOM	0.262571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.375589	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.285653	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.240618	54.02
56.00	05600	RADIOISOTOPE	0.075211	56.00
57.00	05700	CT SCAN	0.018867	57.00
58.00	05800	MRI	0.045481	58.00
60.00	06000	LABORATORY	0.090828	60.00
65.00	06500	RESPIRATORY THERAPY	0.094656	65.00
66.00	06600	PHYSICAL THERAPY	0.457909	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265209	67.00
68.00	06800	SPEECH PATHOLOGY	0.212883	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071868	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.225784	90.00
91.00	09100	EMERGENCY	0.131718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257998	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part II Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,016,464	583,092	4,433,372	0	0	50.00
51.00	05100	RECOVERY ROOM	1,376,289	52,298	1,323,991	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,068,066	125,331	942,735	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,561,740	441,891	4,119,849	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	3,053,921	356,862	2,697,059	0	0	54.02
56.00	05600	RADIOISOTOPE	528,075	24,725	503,350	0	0	56.00
57.00	05700	CT SCAN	841,549	90,034	751,515	0	0	57.00
58.00	05800	MRI	567,333	101,069	466,264	0	0	58.00
60.00	06000	LABORATORY	4,979,155	272,242	4,706,913	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,185,925	106,697	1,079,228	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,298,098	317,914	2,980,184	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,965	5,531	275,434	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	32,090	3,220	28,870	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	367,870	10,603	357,267	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	687,496	18,310	669,186	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,854,149	74,396	2,779,753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,445,120	265,013	10,180,107	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,105,369	126,495	978,874	0	0	90.00
91.00	09100	EMERGENCY	3,863,593	439,665	3,423,928	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,698,860	264,723	1,434,137	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	47,812,127	3,680,111	44,132,016	0	0	200.00
201.00		Less Observation Beds	1,698,860	264,723	1,434,137	0	0	201.00
202.00		Total (line 200 minus line 201)	46,113,267	3,415,388	42,697,879	0	0	202.00

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

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part II Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,016,464	59,580,121	0.084197		50.00
51.00	05100	RECOVERY ROOM	1,376,289	5,241,580	0.262571		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,068,066	2,843,710	0.375589		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,561,740	15,969,502	0.285653		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
54.02	05402	ONCOLOGY	3,053,921	12,691,991	0.240618		54.02
56.00	05600	RADIOISOTOPE	528,075	7,021,252	0.075211		56.00
57.00	05700	CT SCAN	841,549	44,603,413	0.018867		57.00
58.00	05800	MRI	567,333	12,474,059	0.045481		58.00
60.00	06000	LABORATORY	4,979,155	54,819,884	0.090828		60.00
65.00	06500	RESPIRATORY THERAPY	1,185,925	12,528,768	0.094656		65.00
66.00	06600	PHYSICAL THERAPY	3,298,098	7,202,524	0.457909		66.00
67.00	06700	OCCUPATIONAL THERAPY	280,965	1,059,409	0.265209		67.00
68.00	06800	SPEECH PATHOLOGY	32,090	150,740	0.212883		68.00
69.00	06900	ELECTROCARDIOLOGY	367,870	6,903,251	0.053289		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	687,496	15,236,402	0.045122		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,854,149	15,565,732	0.183361		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,445,120	145,337,457	0.071868		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	0	0	0.000000		76.01
76.03	03951	WOUND CARE	0	0	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,105,369	4,895,688	0.225784		90.00
91.00	09100	EMERGENCY	3,863,593	29,332,279	0.131718		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,698,860	6,584,784	0.257998		92.00
200.00		Subtotal (sum of lines 50 thru 199)	47,812,127	460,042,546			200.00
201.00		Less Observation Beds	1,698,860	0			201.00
202.00		Total (line 200 minus line 201)	46,113,267	460,042,546			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

Title V | 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	8,615,174		8,615,174	0	8,615,174	30.00
31.00	03100	INTENSIVE CARE UNIT	2,639,864		2,639,864	0	2,639,864	31.00
43.00	04300	NURSERY	402,153		402,153	0	402,153	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,016,464		5,016,464	0	5,016,464	50.00
51.00	05100	RECOVERY ROOM	1,376,289		1,376,289	0	1,376,289	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,068,066		1,068,066	0	1,068,066	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,561,740		4,561,740	0	4,561,740	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	3,053,921		3,053,921	0	3,053,921	54.02
56.00	05600	RADIOISOTOPE	528,075		528,075	0	528,075	56.00
57.00	05700	CT SCAN	841,549		841,549	0	841,549	57.00
58.00	05800	MRI	567,333		567,333	0	567,333	58.00
60.00	06000	LABORATORY	4,979,155		4,979,155	0	4,979,155	60.00
65.00	06500	RESPIRATORY THERAPY	1,185,925	0	1,185,925	0	1,185,925	65.00
66.00	06600	PHYSICAL THERAPY	3,298,098	0	3,298,098	0	3,298,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,965	0	280,965	0	280,965	67.00
68.00	06800	SPEECH PATHOLOGY	32,090	0	32,090	0	32,090	68.00
69.00	06900	ELECTROCARDIOLOGY	367,870		367,870	0	367,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	687,496		687,496	0	687,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,854,149		2,854,149	0	2,854,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,445,120		10,445,120	0	10,445,120	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,105,369		1,105,369	0	1,105,369	90.00
91.00	09100	EMERGENCY	3,863,593		3,863,593	0	3,863,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,698,860		1,698,860		1,698,860	92.00
200.00		Subtotal (see instructions)	59,469,318	0	59,469,318	0	59,469,318	200.00
201.00		Less Observation Beds	1,698,860		1,698,860		1,698,860	201.00
202.00		Total (see instructions)	57,770,458	0	57,770,458	0	57,770,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

Title V | 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	37,791,618		37,791,618			30.00
31.00	03100	INTENSIVE CARE UNIT	3,721,898		3,721,898			31.00
43.00	04300	NURSERY	1,220,749		1,220,749			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,135,498	39,444,623	59,580,121	0.084197	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,747,323	3,494,257	5,241,580	0.262571	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,571,121	272,589	2,843,710	0.375589	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,752,730	14,216,772	15,969,502	0.285653	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	59,637	12,632,354	12,691,991	0.240618	0.000000	54.02
56.00	05600	RADIOISOTOPE	610,777	6,410,475	7,021,252	0.075211	0.000000	56.00
57.00	05700	CT SCAN	7,589,766	37,013,647	44,603,413	0.018867	0.000000	57.00
58.00	05800	MRI	1,053,062	11,420,997	12,474,059	0.045481	0.000000	58.00
60.00	06000	LABORATORY	14,838,289	39,981,595	54,819,884	0.090828	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,652,718	3,876,050	12,528,768	0.094656	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,202,304	6,000,220	7,202,524	0.457909	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,212	957,197	1,059,409	0.265209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	75,390	75,350	150,740	0.212883	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,827,437	5,075,814	6,903,251	0.053289	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,509,808	8,726,594	15,236,402	0.045122	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,094,724	5,471,008	15,565,732	0.183361	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,247,025	97,090,432	145,337,457	0.071868	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	583,917	4,311,771	4,895,688	0.225784	0.000000	90.00
91.00	09100	EMERGENCY	6,132,000	23,200,279	29,332,279	0.131718	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,771,674	4,813,110	6,584,784	0.257998	0.000000	92.00
200.00		Subtotal (see instructions)	178,291,677	324,485,134	502,776,811			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	178,291,677	324,485,134	502,776,811			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet C Part I Date/Time Prepared: 7/31/2017 3:14 pm

Title V | 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.000000	54.02
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part I Date/Time Prepared: 7/31/2017 3:14 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	1,342,451	0	1,342,451	10,908	123.07	30.00
31.00	INTENSIVE CARE UNIT	313,142		313,142	1,540	203.34	31.00
43.00	NURSERY	32,941		32,941	969	33.99	43.00
200.00	Total (lines 30-199)	1,688,534		1,688,534	13,417		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	3,116	383,486				30.00
31.00	INTENSIVE CARE UNIT	629	127,901				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	3,745	511,387				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part II Date/Time Prepared: 7/31/2017 3:14 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	583,092	59,580,121	0.009787	4,890,793	47,866	50.00
51.00	05100	RECOVERY ROOM	52,298	5,241,580	0.009978	415,695	4,148	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	125,331	2,843,710	0.044073	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,891	15,969,502	0.027671	1,611,582	44,594	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	356,862	12,691,991	0.028117	24,480	688	54.02
56.00	05600	RADIOISOTOPE	24,725	7,021,252	0.003521	250,091	881	56.00
57.00	05700	CT SCAN	90,034	44,603,413	0.002019	3,488,481	7,043	57.00
58.00	05800	MRI	101,069	12,474,059	0.008102	415,725	3,368	58.00
60.00	06000	LABORATORY	272,242	54,819,884	0.004966	5,953,341	29,564	60.00
65.00	06500	RESPIRATORY THERAPY	106,697	12,528,768	0.008516	3,867,070	32,932	65.00
66.00	06600	PHYSICAL THERAPY	317,914	7,202,524	0.044139	483,099	21,324	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,531	1,059,409	0.005221	39,718	207	67.00
68.00	06800	SPEECH PATHOLOGY	3,220	150,740	0.021361	41,267	882	68.00
69.00	06900	ELECTROCARDIOLOGY	10,603	6,903,251	0.001536	1,801,289	2,767	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,310	15,236,402	0.001202	1,951,633	2,346	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,396	15,565,732	0.004779	3,437,048	16,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	265,013	145,337,457	0.001823	16,561,118	30,191	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	126,495	4,895,688	0.025838	124,297	3,212	90.00
91.00	09100	EMERGENCY	439,665	29,332,279	0.014989	2,374,703	35,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	264,723	6,584,784	0.040202	644,037	25,892	92.00
200.00		Total (lines 50-199)	3,680,111	460,042,546		48,375,467	309,925	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part III Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,908	0.00	3,116	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,540	0.00	629	0		31.00
43.00	04300	NURSERY	969	0.00	0	0		43.00
200.00		Total (lines 30-199)	13,417		3,745	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part IV | Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part IV | Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,580,121	0.000000	0.000000	4,890,793	50.00
51.00	05100	RECOVERY ROOM	0	5,241,580	0.000000	0.000000	415,695	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,843,710	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,969,502	0.000000	0.000000	1,611,582	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
54.02	05402	ONCOLOGY	0	12,691,991	0.000000	0.000000	24,480	54.02
56.00	05600	RADIOISOTOPE	0	7,021,252	0.000000	0.000000	250,091	56.00
57.00	05700	CT SCAN	0	44,603,413	0.000000	0.000000	3,488,481	57.00
58.00	05800	MRI	0	12,474,059	0.000000	0.000000	415,725	58.00
60.00	06000	LABORATORY	0	54,819,884	0.000000	0.000000	5,953,341	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,528,768	0.000000	0.000000	3,867,070	65.00
66.00	06600	PHYSICAL THERAPY	0	7,202,524	0.000000	0.000000	483,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,059,409	0.000000	0.000000	39,718	67.00
68.00	06800	SPEECH PATHOLOGY	0	150,740	0.000000	0.000000	41,267	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,903,251	0.000000	0.000000	1,801,289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,236,402	0.000000	0.000000	1,951,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,565,732	0.000000	0.000000	3,437,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	145,337,457	0.000000	0.000000	16,561,118	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,895,688	0.000000	0.000000	124,297	90.00
91.00	09100	EMERGENCY	0	29,332,279	0.000000	0.000000	2,374,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,584,784	0.000000	0.000000	644,037	92.00
200.00		Total (lines 50-199)	0	460,042,546			48,375,467	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part IV Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,595,489	0		50.00
51.00	05100	RECOVERY ROOM	0	413,870	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,440,269	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
54.02	05402	ONCOLOGY	0	3,007,327	0		54.02
56.00	05600	RADIOISOTOPE	0	1,586,560	0		56.00
57.00	05700	CT SCAN	0	7,157,803	0		57.00
58.00	05800	MRI	0	2,046,205	0		58.00
60.00	06000	LABORATORY	0	3,455,410	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,465,492	0		65.00
66.00	06600	PHYSICAL THERAPY	0	29,062	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,998	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	814	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	791,232	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,075,558	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	793,137	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,600,841	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	829,225	0		90.00
91.00	09100	EMERGENCY	0	3,618,217	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,023,287	0		92.00
200.00		Total (lines 50-199)	0	53,933,796	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part V Date/Time Prepared: 7/31/2017 3:14 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	0.084197	5,595,489	0	0	471,123	50.00
51.00	05100	RECOVERY ROOM	0.262571	413,870	0	0	108,670	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.375589	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.285653	5,440,269	0	0	1,554,029	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.240618	3,007,327	0	0	723,617	54.02
56.00	05600	RADIOISOTOPE	0.075211	1,586,560	0	0	119,327	56.00
57.00	05700	CT SCAN	0.018867	7,157,803	0	0	135,046	57.00
58.00	05800	MRI	0.045481	2,046,205	0	0	93,063	58.00
60.00	06000	LABORATORY	0.090828	3,455,410	1,998	0	313,848	60.00
65.00	06500	RESPIRATORY THERAPY	0.094656	1,465,492	1,449	0	138,718	65.00
66.00	06600	PHYSICAL THERAPY	0.457909	29,062	0	0	13,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265209	3,998	0	0	1,060	67.00
68.00	06800	SPEECH PATHOLOGY	0.212883	814	0	0	173	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053289	791,232	0	0	42,164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045122	1,075,558	0	0	48,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183361	793,137	0	0	145,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071868	15,600,841	0	27,852	1,121,201	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.225784	829,225	0	0	187,226	90.00
91.00	09100	EMERGENCY	0.131718	3,618,217	0	0	476,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257998	1,023,287	0	0	264,006	92.00
200.00		Subtotal (see instructions)		53,933,796	3,447	27,852	5,957,124	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		53,933,796	3,447	27,852	5,957,124	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part V Date/Time Prepared: 7/31/2017 3:14 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	05402	ONCOLOGY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	181	0		60.00
65.00	06500	RESPIRATORY THERAPY	137	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,002		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	318	2,002		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	318	2,002		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part I Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,342,451	0	1,342,451	10,908	123.07	30.00
31.00	INTENSIVE CARE UNIT	313,142		313,142	1,540	203.34	31.00
43.00	NURSERY	32,941		32,941	969	33.99	43.00
200.00	Total (lines 30-199)	1,688,534		1,688,534	13,417		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,080	132,916				30.00
31.00	INTENSIVE CARE UNIT	229	46,565				31.00
43.00	NURSERY	435	14,786				43.00
200.00	Total (lines 30-199)	1,744	194,267				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part II Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	583,092	59,580,121	0.009787	163,341	1,599	50.00
51.00	05100	RECOVERY ROOM	52,298	5,241,580	0.009978	20,276	202	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	125,331	2,843,710	0.044073	47,753	2,105	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,891	15,969,502	0.027671	101,551	2,810	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	356,862	12,691,991	0.028117	0	0	54.02
56.00	05600	RADIOISOTOPE	24,725	7,021,252	0.003521	3,207	11	56.00
57.00	05700	CT SCAN	90,034	44,603,413	0.002019	150,127	303	57.00
58.00	05800	MRI	101,069	12,474,059	0.008102	15,998	130	58.00
60.00	06000	LABORATORY	272,242	54,819,884	0.004966	312,987	1,554	60.00
65.00	06500	RESPIRATORY THERAPY	106,697	12,528,768	0.008516	94,149	802	65.00
66.00	06600	PHYSICAL THERAPY	317,914	7,202,524	0.044139	24,241	1,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,531	1,059,409	0.005221	2,110	11	67.00
68.00	06800	SPEECH PATHOLOGY	3,220	150,740	0.021361	2,047	44	68.00
69.00	06900	ELECTROCARDIOLOGY	10,603	6,903,251	0.001536	21,148	32	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,310	15,236,402	0.001202	52,165	63	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,396	15,565,732	0.004779	18,891	90	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	265,013	145,337,457	0.001823	955,952	1,743	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	126,495	4,895,688	0.025838	2,240	58	90.00
91.00	09100	EMERGENCY	439,665	29,332,279	0.014989	104,228	1,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	264,723	6,584,784	0.040202	13,807	555	92.00
200.00		Total (lines 50-199)	3,680,111	460,042,546		2,106,218	14,744	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part III Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,908	0.00	1,080	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,540	0.00	229	0		31.00
43.00	04300	NURSERY	969	0.00	435	0		43.00
200.00		Total (lines 30-199)	13,417		1,744	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part IV | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part IV | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,580,121	0.000000	0.000000	163,341	50.00
51.00	05100	RECOVERY ROOM	0	5,241,580	0.000000	0.000000	20,276	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,843,710	0.000000	0.000000	47,753	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,969,502	0.000000	0.000000	101,551	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
54.02	05402	ONCOLOGY	0	12,691,991	0.000000	0.000000	0	54.02
56.00	05600	RADIOISOTOPE	0	7,021,252	0.000000	0.000000	3,207	56.00
57.00	05700	CT SCAN	0	44,603,413	0.000000	0.000000	150,127	57.00
58.00	05800	MRI	0	12,474,059	0.000000	0.000000	15,998	58.00
60.00	06000	LABORATORY	0	54,819,884	0.000000	0.000000	312,987	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,528,768	0.000000	0.000000	94,149	65.00
66.00	06600	PHYSICAL THERAPY	0	7,202,524	0.000000	0.000000	24,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,059,409	0.000000	0.000000	2,110	67.00
68.00	06800	SPEECH PATHOLOGY	0	150,740	0.000000	0.000000	2,047	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,903,251	0.000000	0.000000	21,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,236,402	0.000000	0.000000	52,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,565,732	0.000000	0.000000	18,891	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	145,337,457	0.000000	0.000000	955,952	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,895,688	0.000000	0.000000	2,240	90.00
91.00	09100	EMERGENCY	0	29,332,279	0.000000	0.000000	104,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,584,784	0.000000	0.000000	13,807	92.00
200.00		Total (lines 50-199)	0	460,042,546			2,106,218	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part IV | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
54.02	05402	ONCOLOGY	0	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part V Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.084197	0	0	240,927	0	50.00
51.00	05100	RECOVERY ROOM	0.262571	0	0	29,407	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.375589	0	0	9,585	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.285653	0	0	282,212	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.240618	0	0	88,492	0	54.02
56.00	05600	RADIOISOTOPE	0.075211	0	0	41,934	0	56.00
57.00	05700	CT SCAN	0.018867	0	0	578,844	0	57.00
58.00	05800	MRI	0.045481	0	0	97,069	0	58.00
60.00	06000	LABORATORY	0.090828	0	0	581,500	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.094656	0	0	64,016	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457909	0	0	40,020	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265209	0	0	5,846	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.212883	0	0	1,997	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053289	0	0	43,548	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045122	0	0	58,373	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183361	0	0	7,823	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071868	0	0	659,402	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.225784	0	0	35,047	0	90.00
91.00	09100	EMERGENCY	0.131718	0	0	631,727	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257998	0	0	78,833	0	92.00
200.00		Subtotal (see instructions)		0	0	3,576,602	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	3,576,602	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D Part V Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	20,285		50.00
51.00	05100	RECOVERY ROOM	0	7,721		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,600		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,615		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	05402	ONCOLOGY	0	21,293		54.02
56.00	05600	RADIOISOTOPE	0	3,154		56.00
57.00	05700	CT SCAN	0	10,921		57.00
58.00	05800	MRI	0	4,415		58.00
60.00	06000	LABORATORY	0	52,816		60.00
65.00	06500	RESPIRATORY THERAPY	0	6,059		65.00
66.00	06600	PHYSICAL THERAPY	0	18,326		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,550		67.00
68.00	06800	SPEECH PATHOLOGY	0	425		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,321		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,634		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,434		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,390		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	7,913		90.00
91.00	09100	EMERGENCY	0	83,210		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	20,339		92.00
200.00		Subtotal (see instructions)	0	396,421		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	396,421		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-1 | Date/Time Prepared: 7/31/2017 3:14 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)	10,908	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,908	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)	8,757	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)	3,116	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)	8,615,174	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)	8,615,174	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)	8,615,174	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)	789.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,461,017	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)	2,461,017	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-1 | Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,639,864	1,540	1,714.20	629	1,078,232	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)	4,749,523	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,288,772	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)	511,387	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	309,925	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	821,312	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,467,460	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,151	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	789.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,698,860	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-1 | Date/Time Prepared: 7/31/2017 3:14 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	1,342,451	8,615,174	0.155824	1,698,860	264,723	90.00
91.00	Nursing School cost	0	8,615,174	0.000000	1,698,860	0	91.00
92.00	Allied health cost	0	8,615,174	0.000000	1,698,860	0	92.00
93.00	All other Medical Education	0	8,615,174	0.000000	1,698,860	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-1 | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,908	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,908	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)	8,757	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,080	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)	969	15.00
16.00	Nursery days (title V or XIX only)	435	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)	8,615,174	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)	8,615,174	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)	8,615,174	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)	789.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	852,984	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)	852,984	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-1 | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	402,153	969	415.02	435	180,534	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,639,864	1,540	1,714.20	229	392,552	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)	212,702	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,638,772	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)	194,267	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,744	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	209,011	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,429,761	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,151	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	789.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,698,860	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-1 | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,342,451	8,615,174	0.155824	1,698,860	264,723	90.00
91.00	Nursing School cost	0	8,615,174	0.000000	1,698,860	0	91.00
92.00	Allied health cost	0	8,615,174	0.000000	1,698,860	0	92.00
93.00	All other Medical Education	0	8,615,174	0.000000	1,698,860	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-3 | Date/Time Prepared: 7/31/2017 3:14 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		7,536,824		30.00
31.00	03100	INTENSIVE CARE UNIT		2,330,873		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.084197	4,890,793	411,790	50.00
51.00	05100	RECOVERY ROOM	0.262571	415,695	109,149	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.375589	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.285653	1,611,582	460,353	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.240618	24,480	5,890	54.02
56.00	05600	RADIOISOTOPE	0.075211	250,091	18,810	56.00
57.00	05700	CT SCAN	0.018867	3,488,481	65,817	57.00
58.00	05800	MRI	0.045481	415,725	18,908	58.00
60.00	06000	LABORATORY	0.090828	5,953,341	540,730	60.00
65.00	06500	RESPIRATORY THERAPY	0.094656	3,867,070	366,041	65.00
66.00	06600	PHYSICAL THERAPY	0.457909	483,099	221,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265209	39,718	10,534	67.00
68.00	06800	SPEECH PATHOLOGY	0.212883	41,267	8,785	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053289	1,801,289	95,989	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045122	1,951,633	88,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183361	3,437,048	630,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071868	16,561,118	1,190,214	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.225784	124,297	28,064	90.00
91.00	09100	EMERGENCY	0.131718	2,374,703	312,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257998	644,037	166,160	92.00
200.00		Total (sum of lines 50-94 and 96-98)		48,375,467	4,749,523	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)		48,375,467		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet D-3 | Date/Time Prepared: 7/31/2017 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		340,954		30.00
31.00	03100	INTENSIVE CARE UNIT		184,976		31.00
43.00	04300	NURSERY		66,420		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.084197	163,341	13,753	50.00
51.00	05100	RECOVERY ROOM	0.262571	20,276	5,324	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.375589	47,753	17,936	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.285653	101,551	29,008	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.240618	0	0	54.02
56.00	05600	RADIOISOTOPE	0.075211	3,207	241	56.00
57.00	05700	CT SCAN	0.018867	150,127	2,832	57.00
58.00	05800	MRI	0.045481	15,998	728	58.00
60.00	06000	LABORATORY	0.090828	312,987	28,428	60.00
65.00	06500	RESPIRATORY THERAPY	0.094656	94,149	8,912	65.00
66.00	06600	PHYSICAL THERAPY	0.457909	24,241	11,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265209	2,110	560	67.00
68.00	06800	SPEECH PATHOLOGY	0.212883	2,047	436	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053289	21,148	1,127	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045122	52,165	2,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183361	18,891	3,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071868	955,952	68,702	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.225784	2,240	506	90.00
91.00	09100	EMERGENCY	0.131718	104,228	13,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.257998	13,807	3,562	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,106,218	212,702	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)		2,106,218		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet E Part A Date/Time Prepared: 7/31/2017 3:14 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)	4,083,033	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,794,658	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)	40,105	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	4,615,639	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	66.11	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.12	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.58	31.00
32.00	Sum of lines 30 and 31	19.70	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.56	33.00
34.00	Disproportionate share adjustment (see instructions)	95,600	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet E Part A Date/Time Prepared: 7/31/2017 3:14 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000070003	0.000068328	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	448,449	408,428	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	262,208	168,966	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	431,174		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,444,570		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)		7,444,570	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		555,848	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)		8,000,418	59.00
60.00	Primary payer payments		9,966	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,990,452	61.00
62.00	Deductibles billed to program beneficiaries		1,013,124	62.00
63.00	Coinsurance billed to program beneficiaries		13,566	63.00
64.00	Allowable bad debts (see instructions)		52,108	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		33,870	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,112	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,997,632	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-18,839	70.93
70.94	HRR adjustment amount (see instructions)		-19,620	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet E Part A Date/Time Prepared: 7/31/2017 3:14 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,959,173	71.00
71.01	Sequestration adjustment (see instructions)		139,183	71.01
72.00	Interim payments		6,808,837	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		11,153	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,268,322	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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet E Part B Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,320	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,957,124	2.00
3.00	PPS payments	5,108,495	3.00
4.00	Outlier payment (see instructions)	13,245	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,320	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	31,299	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	31,299	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	31,299	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28,979	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,320	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,121,740	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	5,892	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,050,844	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)	4,067,324	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)	4,067,324	30.00
31.00	Primary payer payments	4,167	31.00
32.00	Subtotal (line 30 minus line 31)	4,063,157	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)	145,579	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	94,626	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	102,299	36.00
37.00	Subtotal (see instructions)	4,157,783	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)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,157,783	40.00
40.01	Sequestration adjustment (see instructions)	83,156	40.01
41.00	Interim payments	4,131,097	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-56,470	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: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet E-1 Part I | Date/Time Prepared: 7/31/2017 3:14 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,734,027		3,980,400	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		41,410		83,397	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/19/2016	33,400	08/19/2016	67,300	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)		33,400		67,300	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)		6,808,837		4,131,097	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		11,153		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		56,470	6.02
7.00	Total Medicare program liability (see instructions)		6,819,990		4,074,627	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: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet E-1 Part II Date/Time Prepared: 7/31/2017 3:14 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	3,309	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,745	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,547	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	10,297	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	502,776,811	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,476,652	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet G | Date/Time Prepared: 7/31/2017 3:14 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	-431,929	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	20,383,853	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,158,967	0	0	0	6.00
7.00	Inventory	1,770,436	0	0	0	7.00
8.00	Prepaid expenses	944,587	0	0	0	8.00
9.00	Other current assets	155,171	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)	18,663,151	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,360,405	0	0	0	12.00
13.00	Land improvements	1,127,407	0	0	0	13.00
14.00	Accumulated depreciation	-774,126	0	0	0	14.00
15.00	Buildings	25,520,672	0	0	0	15.00
16.00	Accumulated depreciation	-7,072,715	0	0	0	16.00
17.00	Leasehold improvements	14,332,674	0	0	0	17.00
18.00	Accumulated depreciation	-5,147,798	0	0	0	18.00
19.00	Fixed equipment	2,300,861	0	0	0	19.00
20.00	Accumulated depreciation	-1,512,067	0	0	0	20.00
21.00	Automobiles and trucks	154,026	0	0	0	21.00
22.00	Accumulated depreciation	-110,914	0	0	0	22.00
23.00	Major movable equipment	22,662,261	0	0	0	23.00
24.00	Accumulated depreciation	-15,490,091	0	0	0	24.00
25.00	Minor equipment depreciable	5,173,141	0	0	0	25.00
26.00	Accumulated depreciation	-4,097,007	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)	39,426,729	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,848,577	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,848,577	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,938,457	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,038,135	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,631,497	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-338,882,683	0	0	0	43.00
44.00	Other current liabilities	1,624,945	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-332,588,106	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	200,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,895,936	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,095,936	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-330,492,170	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	392,430,627				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)	392,430,627	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,938,457	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet G-1 | Date/Time Prepared: 7/31/2017 3:14 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		359,268,231		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,162,396				2.00
3.00	Total (sum of line 1 and line 2)		392,430,627		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)		392,430,627		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)		392,430,627		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: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/31/2017 3:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	39,012,367		39,012,367	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	39,012,367		39,012,367	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,721,898		3,721,898	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)	3,721,898		3,721,898	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,734,265		42,734,265	17.00
18.00	Ancillary services	126,561,965	292,667,830	419,229,795	18.00
19.00	Outpatient services	8,487,591	32,325,160	40,812,751	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	177,783,821	324,992,990	502,776,811	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		69,792,916		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)		69,792,916		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2016 To 02/28/2017 | Worksheet G-3 | Date/Time Prepared: 7/31/2017 3:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	502,776,811	1.00
2.00	Less contractual allowances and discounts on patients' accounts	400,240,684	2.00
3.00	Net patient revenues (line 1 minus line 2)	102,536,127	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	69,792,916	4.00
5.00	Net income from service to patients (line 3 minus line 4)	32,743,211	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	419,189	24.00
25.00	Total other income (sum of lines 6-24)	419,189	25.00
26.00	Total (line 5 plus line 25)	33,162,400	26.00
27.00	ROUNDING	4	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	33,162,396	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0133	Period: From 03/01/2016 To 02/28/2017	Worksheet L Parts I-III Date/Time Prepared: 7/31/2017 3:14 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	548,912	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,936	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)	28.21	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)	555,848	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