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: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/23/2018 9:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/23/2018 Time: 9:40 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MAJOR HOSPITAL (15-0097) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	120,161	87,470	0	-120,847	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	120,161	87,471	0	-120,847	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: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 9:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 150 WEST WASHINGTON ST	PO Box:			1.00
2.00	City: SHELBYVILLE	State: IN	Zip Code: 46176-	County: IN	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	MAJOR HOSPITAL	150097	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	MAJOR HOSPITAL	157418	99915		03/22/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	278	992	0	0	1,156	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 9:04 pm

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 9:04 pm

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2018 9:04 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	276,870	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	91.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2018 9:04 pm

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2018 9:04 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/20/2018	Y	03/20/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2018 9:04 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?	N		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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/22/2018 9:04 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		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: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2018 9:04 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	40	14,600	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)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		46	16,790	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		46				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2018 9:04 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,315	277	9,744			1.00
2.00	HMO and other (see instructions)	1,501	2,140				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,315	277	9,744			7.00
8.00	INTENSIVE CARE UNIT	711	0	1,565			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	5,026	277	11,309	0.00	706.45	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	6,852	565	11,502	0.00	7.17	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	0	0	0	0.00	0.00	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	713.62	27.00
28.00	Observation Bed Days		165	618			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	9	36			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2018 9:04 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	1,314	68	2,947	1.00
2.00	HMO and other (see instructions)			349	591		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	1,314	68	2,947	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2018 9:04 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	48,446,333	0	48,446,333	1,484,322.00	32.64	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		411,405	0	411,405	2,344.00	175.51	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		5,842,422	0	5,842,422	9,377.00	623.06	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)		5,082,282	160,224	5,242,506	109,756.00	47.77	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		368,987	0	368,987	5,314.00	69.44	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		935,849	0	935,849	5,502.00	170.09	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,943,511	0	12,943,511			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,196,488	0	1,196,488			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		23,608	0	23,608			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		784,944	0	784,944			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	595,037	0	595,037	12,131.00	49.05	26.00
27.00	Administrative & General	5.00	9,200,535	-160,224	9,040,311	263,466.00	34.31	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2018 9:04 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,247,634	0	1,247,634	8,390.00	148.70	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,300,723	0	1,300,723	52,316.00	24.86	30.00
31.00	Laundry & Linen Service	8.00	29,933	0	29,933	1,679.00	17.83	31.00
32.00	Housekeeping	9.00	1,420,329	0	1,420,329	86,648.00	16.39	32.00
33.00	Housekeeping under contract (see instructions)		296,905	0	296,905	4,099.00	72.43	33.00
34.00	Dietary	10.00	731,559	-568,307	163,252	10,110.00	16.15	34.00
35.00	Dietary under contract (see instructions)		321,307	0	321,307	8,373.00	38.37	35.00
36.00	Cafeteria	11.00	0	568,307	568,307	38,244.00	14.86	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	686,467	0	686,467	18,477.00	37.15	38.00
39.00	Central Services and Supply	14.00	280,506	-280,506	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,145,927	0	1,145,927	27,454.00	41.74	40.00
41.00	Medical Records & Medical Records Library	16.00	784,511	0	784,511	36,248.00	21.64	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: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/22/2018 9:04 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)		44,469,757	0	44,469,757	1,495,807.00	29.73	1.00
2.00	Excluded area salaries (see instructions)		5,082,282	160,224	5,242,506	109,756.00	47.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)		39,387,475	-160,224	39,227,251	1,386,051.00	28.30	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,304,836	0	1,304,836	10,816.00	120.64	4.00
5.00	Subtotal wage-related costs (see inst.)		12,967,119	0	12,967,119	0.00	33.06	5.00
6.00	Total (sum of lines 3 thru 5)		53,659,430	-160,224	53,499,206	1,396,867.00	38.30	6.00
7.00	Total overhead cost (see instructions)		18,041,373	-440,730	17,600,643	567,635.00	31.01	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/22/2018 9:04 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,016,000	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	36,000	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)	9,237,820	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	43,954	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	79,054	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	88,110	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	152,603	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	3,259,110	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	31,495	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	4,405	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,948,551	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/22/2018 9:04 pm

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

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-0097 | Component CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	3,910	26	0	3,936	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	286.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	3.18	0.00	3.18	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		7.07	0.00	7.07	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		3.82	0.17	3.99	8.00
9.00	Physical Therapy Supervisor		0.01	0.00	0.01	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.05	0.00	0.05	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		1.89	0.00	1.89	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		26900			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,808	252	56	22	3,138	21.00
22.00	Skilled Nursing Visit Charges	623,154	55,944	12,432	4,884	696,414	22.00
23.00	Physical Therapy Visits	2,412	304	8	13	2,737	23.00
24.00	Physical Therapy Visit Charges	514,416	65,776	1,712	2,743	584,647	24.00
25.00	Occupational Therapy Visits	0	0	0	0	0	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00
27.00	Speech Pathology Visits	12	0	0	0	12	27.00
28.00	Speech Pathology Visit Charges	2,724	0	0	0	2,724	28.00
29.00	Medical Social Service Visits	35	5	0	1	41	29.00
30.00	Medical Social Service Visit Charges	10,780	1,540	0	308	12,628	30.00
31.00	Home Health Aide Visits	822	98	4	0	924	31.00
32.00	Home Health Aide Visit Charges	92,064	10,976	448	0	103,488	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,089	659	68	36	6,852	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,243,138	134,236	14,592	7,935	1,399,901	35.00
36.00	Total Number of Episodes (standard/non outlier)	332		22	4	358	36.00
37.00	Total Number of Outlier Episodes		14		0	14	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/22/2018 9:04 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)	0.272629	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,805,325	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	500,999	5.00
6.00	Medicaid charges	74,129,476	6.00
7.00	Medicaid cost (line 1 times line 6)	20,209,845	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,903,521	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	8,966	9.00
10.00	Stand-alone CHIP charges	28,843	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	7,863	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,903,521	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,147,694	876,075	2,023,769	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	312,895	876,075	1,188,970	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	312,895	876,075	1,188,970	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,762,856	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	499,527	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	768,503	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,994,353	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,903,210	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,092,180	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,995,701	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/22/2018 9:04 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		8,350,255	8,350,255	0	8,350,255	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	595,037	11,840,427	12,435,464	0	12,435,464	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,200,535	12,069,485	21,270,020	-388,924	20,881,096	5.00
7.00	00700	OPERATION OF PLANT	1,300,723	1,502,411	2,803,134	0	2,803,134	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,933	252,760	282,693	0	282,693	8.00
9.00	00900	HOUSEKEEPING	1,420,329	643,115	2,063,444	0	2,063,444	9.00
10.00	01000	DIETARY	731,559	1,299,596	2,031,155	-1,577,890	453,265	10.00
11.00	01100	CAFETERIA	0	0	0	1,577,890	1,577,890	11.00
13.00	01300	NURSING ADMINISTRATION	686,467	244,654	931,121	0	931,121	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	280,506	330,649	611,155	-611,155	0	14.00
15.00	01500	PHARMACY	1,145,927	9,164,817	10,310,744	0	10,310,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	784,511	334,175	1,118,686	0	1,118,686	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,047,730	1,332,042	7,379,772	30,481	7,410,253	30.00
31.00	03100	INTENSIVE CARE UNIT	1,243,706	211,460	1,455,166	0	1,455,166	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,675,169	1,536,042	4,211,211	271,745	4,482,956	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,465,108	850,546	3,315,654	0	3,315,654	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,600,232	2,968,789	5,569,021	0	5,569,021	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	1,188,087	846,721	2,034,808	0	2,034,808	56.01
57.00	05700	CT SCAN	362,786	626,699	989,485	0	989,485	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	470,157	429,369	899,526	0	899,526	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,870,031	3,425,489	5,295,520	0	5,295,520	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	973,755	195,281	1,169,036	0	1,169,036	65.00
65.01	06501	SLEEP LAB	479,901	203,410	683,311	0	683,311	65.01
66.00	06600	PHYSICAL THERAPY	1,669,685	332,938	2,002,623	0	2,002,623	66.00
69.00	06900	ELECTROCARDIOLOGY	528,353	1,615,380	2,143,733	0	2,143,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,566	4,147,433	4,291,999	-1,965,832	2,326,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,965,832	1,965,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	854,246	320,786	1,175,032	0	1,175,032	90.00
91.00	09100	EMERGENCY	2,364,134	1,636,480	4,000,614	308,929	4,309,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,250,878	200,730	1,451,608	0	1,451,608	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	1,171,210	261,505	1,432,715	0	1,432,715	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,535,261	67,173,444	111,708,705	-388,924	111,319,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	3,569	3,569	0	3,569	190.01
190.05	19005	MARKETING	0	0	0	388,924	388,924	190.05
190.07	19007	I-74 CAMPUS	8,345	212,026	220,371	0	220,371	190.07
190.08	19008	RAMPART	107,123	200,025	307,148	0	307,148	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	64,001	64,001	0	64,001	190.09
190.11	19011	MHP ADMIN BUILDING	39,703	82,079	121,782	0	121,782	190.11
190.16	19016	RENOVO	94,197	186,192	280,389	0	280,389	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	453,611	469,525	923,136	0	923,136	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,053,638	428,603	3,482,241	0	3,482,241	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	154,455	68,921	223,376	0	223,376	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	48,446,333	68,888,385	117,334,718	0	117,334,718	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/22/2018 9:04 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	-533,377	7,816,878		1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,624	12,425,840		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,714,905	19,166,191		5.00
7.00	00700	OPERATION OF PLANT	0	2,803,134		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	282,693		8.00
9.00	00900	HOUSEKEEPING	0	2,063,444		9.00
10.00	01000	DIETARY	-198,314	254,951		10.00
11.00	01100	CAFETERIA	-833,294	744,596		11.00
13.00	01300	NURSING ADMINISTRATION	-59,287	871,834		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-235,589	10,075,155		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-753	1,117,933		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-143,308	7,266,945		30.00
31.00	03100	INTENSIVE CARE UNIT	-30,985	1,424,181		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-616,621	3,866,335		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-2,414,954	900,700		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,091,877	4,477,144		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	-200,148	1,834,660		56.01
57.00	05700	CT SCAN	-156,589	832,896		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-64,139	835,387		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-266,138	5,029,382		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-27,317	1,141,719		65.00
65.01	06501	SLEEP LAB	-32,392	650,919		65.01
66.00	06600	PHYSICAL THERAPY	-82,885	1,919,738		66.00
69.00	06900	ELECTROCARDIOLOGY	-114,928	2,028,805		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-215,619	2,110,548		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,965,832		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-393,691	781,341		90.00
91.00	09100	EMERGENCY	-844,505	3,465,038		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	1,451,608		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	-560	1,432,155		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,281,799	101,037,982		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	3,569		190.01
190.05	19005	MARKETING	0	388,924		190.05
190.07	19007	I-74 CAMPUS	0	220,371		190.07
190.08	19008	RAMPART	0	307,148		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	64,001		190.09
190.11	19011	MHP ADMIN BUILDING	0	121,782		190.11
190.16	19016	RENOVO	-7,200	273,189		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	923,136		190.18
190.19	19019	MHCD	-21,841	-21,841		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	-1,991,664	1,490,577		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	-7,073	216,303		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,309,577	105,025,141		200.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/22/2018 9:04 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	568,307	1,009,583		1.00
	0		568,307	1,009,583		
	B - CS&R OTHER					
1.00	ADULTS & PEDIATRICS	30.00	13,990	16,491		1.00
2.00	OPERATING ROOM	50.00	124,725	147,020		2.00
3.00	EMERGENCY	91.00	141,791	167,138		3.00
	0		280,506	330,649		
	C - MARKETING					
1.00	MARKETING	190.05	160,224	228,700		1.00
	0		160,224	228,700		
	D - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	66,938	1,898,894		1.00
	0		66,938	1,898,894		
500.00	Grand Total: Increases		1,075,975	3,467,826		500.00

RECLASSIFICATIONS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/22/2018 9:04 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	568,307	1,009,583	0		1.00
	0		568,307	1,009,583			
	B - CS&R OTHER						
1.00	CENTRAL SERVICES & SUPPLY	14.00	280,506	330,649	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		280,506	330,649			
	C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	160,224	228,700	0		1.00
	0		160,224	228,700			
	D - IMPLANTABLE DEVICES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	66,938	1,898,894	0		1.00
	0		66,938	1,898,894			
500.00	Grand Total: Decreases		1,075,975	3,467,826			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2018 9:04 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,978,356	1,313,916	0	1,313,916	391,610	1.00
2.00	Land Improvements	6,109,252	5,257,207	0	5,257,207	109,804	2.00
3.00	Buildings and Fixtures	135,622,625	16,442,978	0	16,442,978	102,244,649	3.00
4.00	Building Improvements	6,807,782	54,659,310	0	54,659,310	2,167,528	4.00
5.00	Fixed Equipment	926,083	6,075,664	0	6,075,664	145,225	5.00
6.00	Movable Equipment	34,989,163	19,871,688	0	19,871,688	6,927,295	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	186,433,261	103,620,763	0	103,620,763	111,986,111	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	186,433,261	103,620,763	0	103,620,763	111,986,111	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,900,662	0	1.00
2.00	Land Improvements	11,256,655	0	2.00
3.00	Buildings and Fixtures	49,820,954	0	3.00
4.00	Building Improvements	59,299,564	0	4.00
5.00	Fixed Equipment	6,856,522	0	5.00
6.00	Movable Equipment	47,933,556	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	178,067,913	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	178,067,913	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2018 9:04 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	5,677,707	0	2,656,902	0	0	1.00
3.00	Total (sum of lines 1-2)	5,677,707	0	2,656,902	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	15,646	8,350,255		1.00
3.00	Total (sum of lines 1-2)	15,646	8,350,255		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2018 9:04 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	178,067,913	0	178,067,913	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	178,067,913	0	178,067,913	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	5,666,267	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	5,666,267	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,134,965	0	0	15,646	7,816,878	1.00
3.00	Total (sum of lines 1-2)	2,134,965	0	0	15,646	7,816,878	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/22/2018 9:04 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)	B	-521,937	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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)	A	-3,847	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,443,634			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-313,579	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CASE MANAGEMENT	B	-7,050	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/22/2018 9:04 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	
34.00	FOOD AND NUTRITION	B	-14,906	DIETARY	10.00	0	34.00
34.01	DIABETIC ED	B	-56,913	NURSING ADMINISTRATION	13.00	0	34.01
35.00	CAFETERIA - EMP	A	-519,715	CAFETERIA	11.00	0	35.00
36.00	MH OTHER REVENUES RENTAL INCOME	B	-11,440	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	MH INFO. SYSTEMS CONTRACT LABOR	A	-506,664	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MH PATIENT ACCESS CONTRACT LABOR	A	-7,581	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	MH ACCOUNTING CONTRACT LABOR	A	-155,832	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MH ADMINISTRATION CONTRACT LABOR	A	-511,440	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MH EDUCATION CLASS REVENUE	B	-12,489	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	MH ACCOUNTING VENDOR REBATES	B	-11,395	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MH OTHER REVENUES PURCHASE DISCOUNTS	B	-3,196	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MH OTHER REVENUES REAPPOINTMENT FEES	B	-2,688	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MH OTHER REVENUES MISCELLANEOUS INCO	B	-11,782	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	MH IT - RENTAL INCOME	B	-16,555	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	MH CL NUTR/DIAB ED CLASS REVENUE	B	-2,060	NURSING ADMINISTRATION	13.00	0	45.04
45.05	MH PHARMACY VENDOR REBATES	B	-30,831	PHARMACY	15.00	0	45.05
45.06	MH OTHER REVENUES XEROX AND COPYING	B	-753	MEDICAL RECORDS & LIBRARY	16.00	0	45.06
45.07	MH OTHER REVENUES BABY PHOTO INCOME	B	-200	ADULTS & PEDIATRICS	30.00	0	45.07
45.08	MH ICU OTHER INCOME	B	-1,250	INTENSIVE CARE UNIT	31.00	0	45.08
45.09	MH REHAB SVCS-SWK CONTRACT LABOR	A	-39,732	PHYSICAL THERAPY	66.00	0	45.09
45.10	MH CAR MGT & REHAB CONTRACT LABOR	A	-53,258	ELECTROCARDIOLOGY	69.00	0	45.10
45.11	MH CENTRAL SUPPLY VENDOR REBATES	B	-131,842	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45.11
45.12	MH MED. SPEC. CNTR RENTAL INCOME	B	-206,416	CLINIC	90.00	0	45.12
45.13	MEALS ON WHEELS	A	-183,408	DIETARY	10.00	0	45.13
45.14	IHHA/AHA DUES	A	-5,758	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	PROMOTIONAL GIFTS	A	-4,840	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.15
45.16	PROMOTIONAL GIFTS	A	-1,806	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	PROMOTIONAL GIFTS	A	-268	NURSING ADMINISTRATION	13.00	0	45.17
45.19	PROMOTIONAL GIFTS	A	-950	ADULTS & PEDIATRICS	30.00	0	45.19
45.20	PROMOTIONAL GIFTS	A	-815	OPERATING ROOM	50.00	0	45.20
45.21	PROMOTIONAL GIFTS	A	-584	RADIOLOGY-DIAGNOSTIC	54.00	0	45.21
45.23	PROMOTIONAL GIFTS	A	-1,206	ONCOLOGY	56.01	0	45.23
45.24	PROMOTIONAL GIFTS	A	-2,066	RESPIRATORY THERAPY	65.00	0	45.24
45.25	PROMOTIONAL GIFTS	A	-268	SLEEP LAB	65.01	0	45.25
45.26	PROMOTIONAL GIFTS	A	-9,517	PHYSICAL THERAPY	66.00	0	45.26
45.27	PROMOTIONAL GIFTS	A	-2,066	ELECTROCARDIOLOGY	69.00	0	45.27
45.28	PROMOTIONAL GIFTS	A	-102	HOME HEALTH AGENCY	101.00	0	45.28
45.29	PROMOTIONAL GIFTS	A	-3,391	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	45.29
45.30	ADVERTISING EXPENSE	A	-396	ADMINISTRATIVE & GENERAL	5.00	0	45.30
45.31	ADVERTISING EXPENSE	A	-168	RADIOLOGY-DIAGNOSTIC	54.00	0	45.31
45.32	ADVERTISING EXPENSE	A	-68	ONCOLOGY	56.01	0	45.32
45.34	ADVERTISING EXPENSE	A	-300	PHYSICAL THERAPY	66.00	0	45.34
45.35	COMMUNITY OUTREACH	A	-452,035	ADMINISTRATIVE & GENERAL	5.00	0	45.35
45.37	HAF EXPENSE	A	-46	NURSING ADMINISTRATION	13.00	0	45.37
45.38	HAF EXPENSE	A	-204,758	PHARMACY	15.00	0	45.38
45.39	HAF EXPENSE	A	-142,158	ADULTS & PEDIATRICS	30.00	0	45.39
45.40	HAF EXPENSE	A	-29,735	INTENSIVE CARE UNIT	31.00	0	45.40
45.41	HAF EXPENSE	A	-235,806	OPERATING ROOM	50.00	0	45.41
45.42	HAF EXPENSE	A	-41,088	ANESTHESIOLOGY	53.00	0	45.42
45.43	HAF EXPENSE	A	-162,554	RADIOLOGY-DIAGNOSTIC	54.00	0	45.43
45.44	HAF EXPENSE	A	-31,719	ONCOLOGY	56.01	0	45.44
45.45	HAF EXPENSE	A	-156,589	CT SCAN	57.00	0	45.45
45.46	HAF EXPENSE	A	-64,139	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	45.46
45.47	HAF EXPENSE	A	-266,138	LABORATORY	60.00	0	45.47

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/22/2018 9:04 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	
45.48	HAF EXPENSE	A	-25,251	RESPIRATORY THERAPY	65.00	0	45.48
45.49	HAF EXPENSE	A	-32,124	SLEEP LAB	65.01	0	45.49
45.50	HAF EXPENSE	A	-31,598	PHYSICAL THERAPY	66.00	0	45.50
45.51	HAF EXPENSE	A	-37,694	ELECTROCARDIOLOGY	69.00	0	45.51
45.52	HAF EXPENSE	A	-83,777	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45.52
45.53	HAF EXPENSE	A	-1,586	CLINIC	90.00	0	45.53
45.54	HAF EXPENSE	A	-452,028	EMERGENCY	91.00	0	45.54
45.55	HAF EXPENSE	A	-458	HOME HEALTH AGENCY	101.00	0	45.55
45.56	HAF EXPENSE	A	-21,841	MHCD	190.19	0	45.56
45.57	HAF EXPENSE	A	-15,811	HOSPITALIST	192.01	0	45.57
45.58	HAF EXPENSE	A	-3,682	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	45.58
45.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.59
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,309,577				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2018 9:04 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	34,474	0	34,474	179,000	345	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	31,413	0	31,413	179,000	314	2.00
3.00	50.00	OPERATING ROOM	380,000	380,000	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	2,643,651	2,232,246	411,405	239,400	2,344	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	928,571	928,571	0	0	0	5.00
6.00	56.01	ONCOLOGY	188,332	161,249	27,083	271,900	162	6.00
7.00	60.00	LABORATORY	58,784	0	58,784	260,300	735	7.00
8.00	66.00	PHYSICAL THERAPY	10,000	0	10,000	179,000	96	8.00
9.00	69.00	ELECTROCARDIOLOGY	21,910	21,910	0	0	0	9.00
10.00	90.00	CLINIC	231,988	117,897	114,091	179,000	538	10.00
11.00	91.00	EMERGENCY	677,500	17,496	660,004	179,000	3,312	11.00
12.00	190.16	RENOVO	7,200	7,200	0	0	0	12.00
13.00	192.01	HOSPITALIST	1,975,853	1,975,853	0	0	0	13.00
200.00			7,189,676	5,842,422	1,347,254		7,846	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	29,690	1,485	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	27,022	1,351	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	269,785	13,489	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.01	ONCOLOGY	21,177	1,059	0	0	0	6.00
7.00	60.00	LABORATORY	91,981	4,599	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	8,262	413	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.00	CLINIC	46,299	2,315	0	0	0	10.00
11.00	91.00	EMERGENCY	285,023	14,251	0	0	0	11.00
12.00	190.16	RENOVO	0	0	0	0	0	12.00
13.00	192.01	HOSPITALIST	0	0	0	0	0	13.00
200.00			779,239	38,962	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	29,690	4,784	4,784		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	27,022	4,391	4,391		2.00
3.00	50.00	OPERATING ROOM	0	0	0	380,000		3.00
4.00	53.00	ANESTHESIOLOGY	0	269,785	141,620	2,373,866		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	928,571		5.00
6.00	56.01	ONCOLOGY	0	21,177	5,906	167,155		6.00
7.00	60.00	LABORATORY	0	91,981	0	0		7.00
8.00	66.00	PHYSICAL THERAPY	0	8,262	1,738	1,738		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,910		9.00
10.00	90.00	CLINIC	0	46,299	67,792	185,689		10.00
11.00	91.00	EMERGENCY	0	285,023	374,981	392,477		11.00
12.00	190.16	RENOVO	0	0	0	7,200		12.00
13.00	192.01	HOSPITALIST	0	0	0	1,975,853		13.00
200.00			0	779,239	601,212	6,443,634		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,816,878	7,816,878				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,425,840	32,123	12,457,963			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,166,191	773,206	2,353,641	22,293,038	22,293,038	5.00
7.00	00700	OPERATION OF PLANT	2,803,134	239,679	338,639	3,381,452	910,926	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	282,693	36,231	7,793	326,717	88,014	8.00
9.00	00900	HOUSEKEEPING	2,063,444	70,080	369,778	2,503,302	674,362	9.00
10.00	01000	DIETARY	254,951	41,078	42,502	338,531	91,197	10.00
11.00	01100	CAFETERIA	744,596	146,376	147,957	1,038,929	279,876	11.00
13.00	01300	NURSING ADMINISTRATION	871,834	71,394	178,720	1,121,948	302,240	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	88,647	0	88,647	23,881	14.00
15.00	01500	PHARMACY	10,075,155	84,649	298,339	10,458,143	2,817,343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,117,933	61,207	204,245	1,383,385	372,669	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,266,945	675,768	1,578,151	9,520,864	2,564,816	30.00
31.00	03100	INTENSIVE CARE UNIT	1,424,181	112,774	323,795	1,860,750	501,266	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,866,335	674,919	728,944	5,270,198	1,419,733	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	900,700	13,720	641,783	1,556,203	419,224	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,477,144	253,043	676,963	5,407,150	1,456,627	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	1,834,660	465,529	309,315	2,609,504	702,972	56.01
57.00	05700	CT SCAN	832,896	57,209	94,450	984,555	265,228	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	835,387	57,702	122,404	1,015,493	273,563	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,029,382	157,577	486,857	5,673,816	1,528,464	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,141,719	120,606	253,514	1,515,839	408,350	65.00
65.01	06501	SLEEP LAB	650,919	0	124,941	775,860	209,008	65.01
66.00	06600	PHYSICAL THERAPY	1,919,738	323,342	434,697	2,677,777	721,364	66.00
69.00	06900	ELECTROCARDIOLOGY	2,028,805	68,081	137,555	2,234,441	601,934	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,110,548	95,275	20,210	2,226,033	599,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,965,832	0	17,427	1,983,259	534,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	781,341	206,816	222,400	1,210,557	326,111	90.00
91.00	09100	EMERGENCY	3,465,038	375,594	652,410	4,493,042	1,210,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,451,608	201,421	325,662	1,978,691	533,038	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	1,432,155	175,022	304,921	1,912,098	515,098	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,037,982	5,679,068	11,398,013	97,840,222	20,351,617	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,567	0	20,567	5,541	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	3,569	0	0	3,569	961	190.01
190.05	19005	MARKETING	388,924	21,909	41,714	452,547	121,911	190.05
190.07	19007	I-74 CAMPUS	220,371	0	2,173	222,544	59,951	190.07
190.08	19008	RAMPART	307,148	301,324	27,889	636,361	171,429	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	64,001	0	0	64,001	17,241	190.09
190.11	19011	MHP ADMIN BUILDING	121,782	62,987	10,337	195,106	52,559	190.11
190.16	19016	RENOVO	273,189	266,599	24,524	564,312	152,019	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	923,136	0	118,096	1,041,232	280,496	190.18
190.19	19019	MHCD	-21,841	0	0	-21,841	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	1,490,577	6,134	795,005	2,291,716	617,363	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	216,303	1,458,290	40,212	1,714,805	461,950	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/22/2018 9:04 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	4.00	4A	5.00	
202.00	TOTAL (sum lines 118 through 201)	105,025,141	7,816,878	12,457,963	105,025,141	22,293,038	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	4,292,378					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,965	437,696				8.00
9.00	00900	HOUSEKEEPING	44,420	0	3,222,084			9.00
10.00	01000	DIETARY	26,038	0	19,857	475,623		10.00
11.00	01100	CAFETERIA	92,781	0	70,757	0	1,482,343	11.00
13.00	01300	NURSING ADMINISTRATION	45,254	0	34,512	0	29,067	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,190	0	42,852	0	0	14.00
15.00	01500	PHARMACY	53,655	0	40,919	0	43,190	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,796	0	29,587	0	57,024	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	428,339	165,516	326,662	409,804	313,438	30.00
31.00	03100	INTENSIVE CARE UNIT	71,482	0	54,514	65,819	72,551	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	427,801	80,062	326,251	0	126,741	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,697	0	6,632	0	31,468	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,393	52,035	122,319	0	118,211	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	295,077	15,235	225,033	0	58,450	56.01
57.00	05700	CT SCAN	36,262	0	27,654	0	18,181	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	36,574	0	27,893	0	21,688	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	99,881	0	76,172	0	127,361	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	76,447	5,534	58,300	0	50,681	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	204,952	16,951	156,301	0	72,013	66.00
69.00	06900	ELECTROCARDIOLOGY	43,153	0	32,910	0	25,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,390	0	46,055	0	7,211	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	6,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	131,091	0	99,974	0	40,419	90.00
91.00	09100	EMERGENCY	238,072	102,363	181,560	0	124,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	127,672	0	97,366	0	63,402	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	110,938	0	84,604	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,937,320	437,696	2,188,684	475,623	1,407,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,036	0	9,942	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.05	19005	MARKETING	13,887	0	10,590	0	9,598	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	1,010	190.07
190.08	19008	RAMPART	190,996	0	145,658	0	11,044	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	0	190.09
190.11	19011	MHP ADMIN BUILDING	39,925	0	30,447	0	3,610	190.11
190.16	19016	RENOVO	168,985	0	128,872	0	7,910	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,888	0	2,965	0	41,389	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	924,341	0	704,926	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,292,378	437,696	3,222,084	475,623	1,482,343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,533,021					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	211,570				14.00
15.00	01500	PHARMACY	0	0	13,413,250			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,881,461		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	453,216	0	0	103,069	14,285,724	30.00
31.00	03100	INTENSIVE CARE UNIT	104,907	0	0	24,580	2,755,869	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,262	0	0	266,879	8,100,927	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,502	0	0	9,519	2,077,245	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	151,344	7,468,079	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	84,516	0	0	73,068	4,063,855	56.01
57.00	05700	CT SCAN	0	0	0	150,485	1,482,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	63,357	1,438,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	234,194	7,739,888	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	73,283	0	0	30,397	2,218,831	65.00
65.01	06501	SLEEP LAB	33,919	0	0	24,153	1,042,940	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	45,555	3,894,913	66.00
69.00	06900	ELECTROCARDIOLOGY	37,460	0	0	69,601	3,045,406	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	124,826	0	64,769	3,128,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	86,744	0	55,850	2,666,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,413,250	211,242	13,624,492	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	58,445	0	0	10,272	1,876,869	90.00
91.00	09100	EMERGENCY	180,109	0	0	261,272	6,791,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	91,677	0	0	19,213	2,911,059	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	74,762	0	0	12,642	2,710,142	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,421,058	211,570	13,413,250	1,881,461	93,323,819	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	49,086	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	4,530	190.01
190.05	19005	MARKETING	0	0	0	0	608,533	190.05
190.07	19007	I-74 CAMPUS	1,460	0	0	0	284,965	190.07
190.08	19008	RAMPART	15,969	0	0	0	1,171,457	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	81,242	190.09
190.11	19011	MHP ADMIN BUILDING	5,221	0	0	0	326,868	190.11
190.16	19016	RENOVO	11,437	0	0	0	1,033,535	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	1,321,728	190.18
190.19	19019	MHCD	0	0	0	0	-21,841	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	59,846	0	0	0	3,017,167	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	18,030	0	0	0	3,824,052	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,533,021	211,570	13,413,250	1,881,461	105,025,141	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	14,285,724		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,755,869		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,100,927		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,077,245		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,468,079		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	4,063,855		56.01
57.00	05700	CT SCAN	0	1,482,365		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,438,568		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	7,739,888		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	2,218,831		65.00
65.01	06501	SLEEP LAB	0	1,042,940		65.01
66.00	06600	PHYSICAL THERAPY	0	3,894,913		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,045,406		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,128,953		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,666,340		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,624,492		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	1,876,869		90.00
91.00	09100	EMERGENCY	0	6,791,354		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,911,059		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	2,710,142		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	93,323,819		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,086		190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	4,530		190.01
190.05	19005	MARKETING	0	608,533		190.05
190.07	19007	I-74 CAMPUS	0	284,965		190.07
190.08	19008	RAMPART	0	1,171,457		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	81,242		190.09
190.11	19011	MHP ADMIN BUILDING	0	326,868		190.11
190.16	19016	RENOVO	0	1,033,535		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	1,321,728		190.18
190.19	19019	MHCD	0	-21,841		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	3,017,167		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	3,824,052		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	105,025,141		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	32,123	32,123	32,123		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	773,206	773,206	6,081	779,287	5.00
7.00	00700	OPERATION OF PLANT	0	239,679	239,679	873	31,843	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,231	36,231	20	3,077	8.00
9.00	00900	HOUSEKEEPING	0	70,080	70,080	953	23,574	9.00
10.00	01000	DIETARY	0	41,078	41,078	110	3,188	10.00
11.00	01100	CAFETERIA	0	146,376	146,376	381	9,784	11.00
13.00	01300	NURSING ADMINISTRATION	0	71,394	71,394	461	10,565	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	88,647	88,647	0	835	14.00
15.00	01500	PHARMACY	0	84,649	84,649	769	98,475	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,207	61,207	526	13,027	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	675,768	675,768	4,067	89,658	30.00
31.00	03100	INTENSIVE CARE UNIT	0	112,774	112,774	835	17,523	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	674,919	674,919	1,879	49,629	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,720	13,720	1,654	14,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	253,043	253,043	1,745	50,919	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	465,529	465,529	797	24,574	56.01
57.00	05700	CT SCAN	0	57,209	57,209	243	9,272	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	57,702	57,702	315	9,563	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	157,577	157,577	1,255	53,430	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	120,606	120,606	653	14,275	65.00
65.01	06501	SLEEP LAB	0	0	0	322	7,306	65.01
66.00	06600	PHYSICAL THERAPY	0	323,342	323,342	1,120	25,217	66.00
69.00	06900	ELECTROCARDIOLOGY	0	68,081	68,081	355	21,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	95,275	95,275	52	20,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	45	18,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	206,816	206,816	573	11,400	90.00
91.00	09100	EMERGENCY	0	375,594	375,594	1,681	42,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	201,421	201,421	839	18,633	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	175,022	175,022	786	18,006	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,679,068	5,679,068	29,390	711,420	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,567	20,567	0	194	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	34	190.01
190.05	19005	MARKETING	0	21,909	21,909	108	4,262	190.05
190.07	19007	I-74 CAMPUS	0	0	0	6	2,096	190.07
190.08	19008	RAMPART	0	301,324	301,324	72	5,993	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	603	190.09
190.11	19011	MHP ADMIN BUILDING	0	62,987	62,987	27	1,837	190.11
190.16	19016	RENOVO	0	266,599	266,599	63	5,314	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	304	9,805	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	6,134	6,134	2,049	21,581	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,458,290	1,458,290	104	16,148	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,816,878	7,816,878	32,123	779,287	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	272,395					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,457	40,785				8.00
9.00	00900	HOUSEKEEPING	2,819	0	97,426			9.00
10.00	01000	DIETARY	1,652	0	600	46,628		10.00
11.00	01100	CAFETERIA	5,888	0	2,139	0	164,568	11.00
13.00	01300	NURSING ADMINISTRATION	2,872	0	1,044	0	3,227	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,566	0	1,296	0	0	14.00
15.00	01500	PHARMACY	3,405	0	1,237	0	4,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,462	0	895	0	6,331	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,182	15,423	9,877	40,175	34,795	30.00
31.00	03100	INTENSIVE CARE UNIT	4,536	0	1,648	6,453	8,055	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,148	7,460	9,865	0	14,071	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	552	0	201	0	3,494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,179	4,849	3,699	0	13,124	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	18,726	1,420	6,804	0	6,489	56.01
57.00	05700	CT SCAN	2,301	0	836	0	2,018	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,321	0	843	0	2,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,338	0	2,303	0	14,139	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,851	516	1,763	0	5,627	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	13,006	1,579	4,726	0	7,995	66.00
69.00	06900	ELECTROCARDIOLOGY	2,739	0	995	0	2,876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,832	0	1,393	0	801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,319	0	3,023	0	4,487	90.00
91.00	09100	EMERGENCY	15,108	9,538	5,490	0	13,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	8,102	0	2,944	0	7,039	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	7,040	0	2,558	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	186,401	40,785	66,179	46,628	156,290	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	827	0	301	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.05	19005	MARKETING	881	0	320	0	1,066	190.05
190.07	19007	I-74 CAMPUS	0	0	0	0	112	190.07
190.08	19008	RAMPART	12,121	0	4,404	0	1,226	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	0	190.09
190.11	19011	MHP ADMIN BUILDING	2,534	0	921	0	401	190.11
190.16	19016	RENOVO	10,724	0	3,897	0	878	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	247	0	90	0	4,595	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	58,660	0	21,314	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	272,395	40,785	97,426	46,628	164,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	89,563					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,344				14.00
15.00	01500	PHARMACY	0	0	193,330			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	84,448		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,479	0	0	4,632	928,056	30.00
31.00	03100	INTENSIVE CARE UNIT	6,129	0	0	1,105	159,058	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,707	0	0	11,886	807,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,658	0	0	428	37,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,802	344,360	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	4,938	0	0	3,284	532,561	56.01
57.00	05700	CT SCAN	0	0	0	6,763	78,642	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,847	75,999	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	10,525	245,567	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,281	0	0	1,366	153,938	65.00
65.01	06501	SLEEP LAB	1,982	0	0	1,085	10,695	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	2,047	379,032	66.00
69.00	06900	ELECTROCARDIOLOGY	2,189	0	0	3,128	101,405	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,663	0	2,911	180,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	38,681	0	2,510	60,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	193,330	9,494	202,824	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,414	0	0	462	238,494	90.00
91.00	09100	EMERGENCY	10,522	0	0	11,742	485,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,356	0	0	863	245,197	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	4,368	0	0	568	208,348	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,023	94,344	193,330	84,448	5,476,409	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	21,889	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	34	190.01
190.05	19005	MARKETING	0	0	0	0	28,546	190.05
190.07	19007	I-74 CAMPUS	85	0	0	0	2,299	190.07
190.08	19008	RAMPART	933	0	0	0	326,073	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	603	190.09
190.11	19011	MHP ADMIN BUILDING	305	0	0	0	69,012	190.11
190.16	19016	RENOVO	668	0	0	0	288,143	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	10,109	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	3,496	0	0	0	38,192	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,053	0	0	0	1,555,569	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,563	94,344	193,330	84,448	7,816,878	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	928,056		30.00
31.00	03100	INTENSIVE CARE UNIT	0	159,058		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	807,564		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	37,362		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	344,360		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	532,561		56.01
57.00	05700	CT SCAN	0	78,642		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	75,999		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	245,567		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	153,938		65.00
65.01	06501	SLEEP LAB	0	10,695		65.01
66.00	06600	PHYSICAL THERAPY	0	379,032		66.00
69.00	06900	ELECTROCARDIOLOGY	0	101,405		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	180,890		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	60,602		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	202,824		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	238,494		90.00
91.00	09100	EMERGENCY	0	485,815		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	245,197		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	208,348		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,476,409		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,889		190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	34		190.01
190.05	19005	MARKETING	0	28,546		190.05
190.07	19007	I-74 CAMPUS	0	2,299		190.07
190.08	19008	RAMPART	0	326,073		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	603		190.09
190.11	19011	MHP ADMIN BUILDING	0	69,012		190.11
190.16	19016	RENOVO	0	288,143		190.16
190.17	19017	IMA	0	0		190.17
190.18	19018	MD SOLUTIONS	0	10,109		190.18
190.19	19019	MHCD	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	HOSPITALIST	0	38,192		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,555,569		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,816,878		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	285,437					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,173	47,851,296				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,234	9,040,311	-22,293,038	82,753,944		5.00
7.00	00700	OPERATION OF PLANT	8,752	1,300,723	0	3,381,452	247,278	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,323	29,933	0	326,717	1,323	8.00
9.00	00900	HOUSEKEEPING	2,559	1,420,329	0	2,503,302	2,559	9.00
10.00	01000	DIETARY	1,500	163,252	0	338,531	1,500	10.00
11.00	01100	CAFETERIA	5,345	568,307	0	1,038,929	5,345	11.00
13.00	01300	NURSING ADMINISTRATION	2,607	686,467	0	1,121,948	2,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,237	0	0	88,647	3,237	14.00
15.00	01500	PHARMACY	3,091	1,145,927	0	10,458,143	3,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,235	784,511	0	1,383,385	2,235	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,676	6,061,720	0	9,520,864	24,676	30.00
31.00	03100	INTENSIVE CARE UNIT	4,118	1,243,706	0	1,860,750	4,118	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,645	2,799,894	0	5,270,198	24,645	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	501	2,465,108	0	1,556,203	501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,240	2,600,232	0	5,407,150	9,240	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	16,999	1,188,087	0	2,609,504	16,999	56.01
57.00	05700	CT SCAN	2,089	362,786	0	984,555	2,089	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,107	470,157	0	1,015,493	2,107	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,754	1,870,031	0	5,673,816	5,754	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,404	973,755	0	1,515,839	4,404	65.00
65.01	06501	SLEEP LAB	0	479,901	0	775,860	0	65.01
66.00	06600	PHYSICAL THERAPY	11,807	1,669,685	0	2,677,777	11,807	66.00
69.00	06900	ELECTROCARDIOLOGY	2,486	528,353	0	2,234,441	2,486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,479	77,628	0	2,226,033	3,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	66,938	0	1,983,259	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,552	854,246	0	1,210,557	7,552	90.00
91.00	09100	EMERGENCY	13,715	2,505,925	0	4,493,042	13,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,355	1,250,878	0	1,978,691	7,355	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	6,391	1,171,210	0	1,912,098	6,391	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	207,374	43,780,000	-22,293,038	75,547,184	169,215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	751	0	0	20,567	751	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	3,569	0	190.01
190.05	19005	MARKETING	800	160,224	0	452,547	800	190.05
190.07	19007	I-74 CAMPUS	0	8,345	0	222,544	0	190.07
190.08	19008	RAMPART	11,003	107,123	0	636,361	11,003	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	64,001	0	190.09
190.11	19011	MHP ADMIN BUILDING	2,300	39,703	0	195,106	2,300	190.11
190.16	19016	RENOVO	9,735	94,197	0	564,312	9,735	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	453,611	0	1,041,232	0	190.18
190.19	19019	MHCD	0	0	21,841	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	224	3,053,638	0	2,291,716	224	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	53,250	154,455	0	1,714,805	53,250	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	7,816,878	12,457,963		22,293,038	4,292,378	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.385651	0.260347		0.269389	17.358511	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		32,123		779,287	272,395	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000671		0.009417	1.101574	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	409,064					8.00
9.00	00900	HOUSEKEEPING	0	243,396				9.00
10.00	01000	DIETARY	0	1,500	11,309			10.00
11.00	01100	CAFETERIA	0	5,345	0	942,265		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,607	0	18,477	673,932	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,237	0	0	0	14.00
15.00	01500	PHARMACY	0	3,091	0	27,454	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,235	0	36,248	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,689	24,676	9,744	199,239	199,239	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,118	1,565	46,118	46,118	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,825	24,645	0	80,564	80,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	501	0	20,003	20,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,631	9,240	0	75,142	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	14,238	16,999	0	37,154	37,154	56.01
57.00	05700	CT SCAN	0	2,089	0	11,557	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,107	0	13,786	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	5,754	0	80,958	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,172	4,404	0	32,216	32,216	65.00
65.01	06501	SLEEP LAB	0	0	0	0	14,911	65.01
66.00	06600	PHYSICAL THERAPY	15,842	11,807	0	45,776	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,486	0	16,468	16,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,479	0	4,584	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,953	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	7,552	0	25,693	25,693	90.00
91.00	09100	EMERGENCY	95,667	13,715	0	79,178	79,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	7,355	0	40,302	40,302	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	6,391	0	0	32,866	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,064	165,333	11,309	894,870	624,712	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	751	0	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.05	19005	MARKETING	0	800	0	6,101	0	190.05
190.07	19007	I-74 CAMPUS	0	0	0	642	642	190.07
190.08	19008	RAMPART	0	11,003	0	7,020	7,020	190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0	0	0	190.09
190.11	19011	MHP ADMIN BUILDING	0	2,300	0	2,295	2,295	190.11
190.16	19016	RENOVO	0	9,735	0	5,028	5,028	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	224	0	26,309	26,309	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	53,250	0	0	7,926	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	437,696	3,222,084	475,623	1,482,343	1,533,021	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.069994	13.238032	42.057034	1.573170	2.274741	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
			8.00	9.00	10.00	11.00	13.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	40,785	97,426	46,628	164,568	89,563	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.099703	0.400278	4.123088	0.174652	0.132896	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	342,310,485		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	18,753,429		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	4,472,324		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	48,537,052		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,731,960		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	27,537,118		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	05601	ONCOLOGY	0	0	13,294,732		56.01
57.00	05700	CT SCAN	0	0	27,380,885		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	11,527,763		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	42,611,690		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	5,530,682		65.00
65.01	06501	SLEEP LAB	0	0	4,394,578		65.01
66.00	06600	PHYSICAL THERAPY	0	0	8,288,691		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	12,663,881		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59	0	11,784,707		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	41	0	10,161,945		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	38,435,519		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	1,868,981		90.00
91.00	09100	EMERGENCY	0	0	47,538,589		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	3,495,800		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	2,300,159		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	342,310,485		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0		190.01
190.05	19005	MARKETING	0	0	0		190.05
190.07	19007	I-74 CAMPUS	0	0	0		190.07
190.08	19008	RAMPART	0	0	0		190.08
190.09	19009	INTELLIPLEX DEVELOPMENT	0	0	0		190.09
190.11	19011	MHP ADMIN BUILDING	0	0	0		190.11
190.16	19016	RENOVO	0	0	0		190.16
190.17	19017	IMA	0	0	0		190.17
190.18	19018	MD SOLUTIONS	0	0	0		190.18
190.19	19019	MHCD	0	0	0		190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	HOSPITALIST	0	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	211,570	13,413,250	1,881,461		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 9:04 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	2,115.700000	134,132.500000	0.005496		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	94,344	193,330	84,448		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	943.440000	1,933.300000	0.000247		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		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	14,285,724		14,285,724	0	14,285,724	30.00
31.00	03100	INTENSIVE CARE UNIT	2,755,869		2,755,869	0	2,755,869	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,100,927		8,100,927	0	8,100,927	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,077,245		2,077,245	141,620	2,218,865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,468,079		7,468,079	0	7,468,079	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	4,063,855		4,063,855	5,906	4,069,761	56.01
57.00	05700	CT SCAN	1,482,365		1,482,365	0	1,482,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,438,568		1,438,568	0	1,438,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	7,739,888		7,739,888	0	7,739,888	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,218,831	0	2,218,831	0	2,218,831	65.00
65.01	06501	SLEEP LAB	1,042,940	0	1,042,940	0	1,042,940	65.01
66.00	06600	PHYSICAL THERAPY	3,894,913	0	3,894,913	1,738	3,896,651	66.00
69.00	06900	ELECTROCARDIOLOGY	3,045,406		3,045,406	0	3,045,406	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,128,953		3,128,953	0	3,128,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,666,340		2,666,340	0	2,666,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,624,492		13,624,492	0	13,624,492	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,876,869		1,876,869	67,792	1,944,661	90.00
91.00	09100	EMERGENCY	6,791,354		6,791,354	374,981	7,166,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	852,012		852,012		852,012	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,911,059		2,911,059	0	2,911,059	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	2,710,142		2,710,142		2,710,142	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	94,175,831	0	94,175,831	592,037	94,767,868	200.00
201.00		Less Observation Beds	852,012		852,012		852,012	201.00
202.00		Total (see instructions)	93,323,819	0	93,323,819	592,037	93,915,856	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,913,009		16,913,009			30.00
31.00	03100	INTENSIVE CARE UNIT	4,472,324		4,472,324			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,375,194	39,161,858	48,537,052	0.166902	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	348,554	1,383,406	1,731,960	1.199361	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,641,967	24,895,151	27,537,118	0.271200	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	34,638	13,260,094	13,294,732	0.305674	0.000000	56.01
57.00	05700	CT SCAN	4,372,289	23,008,596	27,380,885	0.054139	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,052,300	10,475,463	11,527,763	0.124792	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,257,276	33,354,414	42,611,690	0.181638	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	4,614,174	916,508	5,530,682	0.401186	0.000000	65.00
65.01	06501	SLEEP LAB	5,649	4,388,929	4,394,578	0.237324	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,393,774	6,894,917	8,288,691	0.469907	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,896	10,205,985	12,663,881	0.240480	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,874,871	8,909,836	11,784,707	0.265510	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,978,818	4,183,127	10,161,945	0.262385	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,006,358	28,429,161	38,435,519	0.354477	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	4,230	1,864,751	1,868,981	1.004220	0.000000	90.00
91.00	09100	EMERGENCY	7,727,333	39,811,256	47,538,589	0.142860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,840,420	1,840,420	0.462944	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	272,671	3,223,129	3,495,800	0.832730	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	2,300,159	2,300,159			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	83,803,325	258,507,160	342,310,485			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	83,803,325	258,507,160	342,310,485			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.166902	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1.281129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.271200	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	05601	ONCOLOGY	0.306118	56.01
57.00	05700	CT SCAN	0.054139	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.124792	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.181638	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.401186	65.00
65.01	06501	SLEEP LAB	0.237324	65.01
66.00	06600	PHYSICAL THERAPY	0.470117	66.00
69.00	06900	ELECTROCARDIOLOGY	0.240480	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262385	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354477	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	1.040493	90.00
91.00	09100	EMERGENCY	0.150748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.462944	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.832730	92.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM		100.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,285,724		14,285,724	0	14,285,724	30.00
31.00	03100	INTENSIVE CARE UNIT	2,755,869		2,755,869	0	2,755,869	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,100,927		8,100,927	0	8,100,927	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,077,245		2,077,245	141,620	2,218,865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,468,079		7,468,079	0	7,468,079	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	ONCOLOGY	4,063,855		4,063,855	5,906	4,069,761	56.01
57.00	05700	CT SCAN	1,482,365		1,482,365	0	1,482,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,438,568		1,438,568	0	1,438,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	7,739,888		7,739,888	0	7,739,888	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,218,831	0	2,218,831	0	2,218,831	65.00
65.01	06501	SLEEP LAB	1,042,940	0	1,042,940	0	1,042,940	65.01
66.00	06600	PHYSICAL THERAPY	3,894,913	0	3,894,913	1,738	3,896,651	66.00
69.00	06900	ELECTROCARDIOLOGY	3,045,406		3,045,406	0	3,045,406	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,128,953		3,128,953	0	3,128,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,666,340		2,666,340	0	2,666,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,624,492		13,624,492	0	13,624,492	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,876,869		1,876,869	67,792	1,944,661	90.00
91.00	09100	EMERGENCY	6,791,354		6,791,354	374,981	7,166,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	852,012		852,012		852,012	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,911,059		2,911,059	0	2,911,059	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	2,710,142		2,710,142		2,710,142	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	94,175,831	0	94,175,831	592,037	94,767,868	200.00
201.00		Less Observation Beds	852,012		852,012		852,012	201.00
202.00		Total (see instructions)	93,323,819	0	93,323,819	592,037	93,915,856	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,913,009		16,913,009			30.00
31.00	03100	INTENSIVE CARE UNIT	4,472,324		4,472,324			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,375,194	39,161,858	48,537,052	0.166902	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	348,554	1,383,406	1,731,960	1.199361	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,641,967	24,895,151	27,537,118	0.271200	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	ONCOLOGY	34,638	13,260,094	13,294,732	0.305674	0.000000	56.01
57.00	05700	CT SCAN	4,372,289	23,008,596	27,380,885	0.054139	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,052,300	10,475,463	11,527,763	0.124792	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	9,257,276	33,354,414	42,611,690	0.181638	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	4,614,174	916,508	5,530,682	0.401186	0.000000	65.00
65.01	06501	SLEEP LAB	5,649	4,388,929	4,394,578	0.237324	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,393,774	6,894,917	8,288,691	0.469907	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,896	10,205,985	12,663,881	0.240480	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,874,871	8,909,836	11,784,707	0.265510	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,978,818	4,183,127	10,161,945	0.262385	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,006,358	28,429,161	38,435,519	0.354477	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	4,230	1,864,751	1,868,981	1.004220	0.000000	90.00
91.00	09100	EMERGENCY	7,727,333	39,811,256	47,538,589	0.142860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,840,420	1,840,420	0.462944	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	272,671	3,223,129	3,495,800	0.832730	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	2,300,159	2,300,159			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	83,803,325	258,507,160	342,310,485			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	83,803,325	258,507,160	342,310,485			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ONCOLOGY	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/22/2018 9:04 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	928,056	0	928,056	10,362	89.56	30.00
31.00	INTENSIVE CARE UNIT	159,058		159,058	1,565	101.63	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
200.00	Total (lines 30 through 199)	1,087,114		1,087,114	11,927		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,315	386,451				30.00
31.00	INTENSIVE CARE UNIT	711	72,259				31.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
200.00	Total (lines 30 through 199)	5,026	458,710				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/22/2018 9:04 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	807,564	48,537,052	0.016638	3,215,023	53,492	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,362	1,731,960	0.021572	104,548	2,255	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344,360	27,537,118	0.012505	1,372,623	17,165	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	532,561	13,294,732	0.040058	19,558	783	56.01
57.00	05700	CT SCAN	78,642	27,380,885	0.002872	2,450,808	7,039	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,999	11,527,763	0.006593	491,057	3,238	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	245,567	42,611,690	0.005763	4,657,151	26,839	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	153,938	5,530,682	0.027833	2,476,608	68,931	65.00
65.01	06501	SLEEP LAB	10,695	4,394,578	0.002434	4,946	12	65.01
66.00	06600	PHYSICAL THERAPY	379,032	8,288,691	0.045729	843,137	38,556	66.00
69.00	06900	ELECTROCARDIOLOGY	101,405	12,663,881	0.008007	1,287,920	10,312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,890	11,784,707	0.015350	1,647,360	25,287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	60,602	10,161,945	0.005964	2,277,164	13,581	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	202,824	38,435,519	0.005277	4,961,328	26,181	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	238,494	1,868,981	0.127606	1,711	218	90.00
91.00	09100	EMERGENCY	485,815	47,538,589	0.010219	3,772,667	38,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	55,350	1,840,420	0.030075	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	245,197	3,495,800	0.070140	43,225	3,032	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	4,236,297	318,624,993		29,626,834	335,474	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,362	0.00	4,315	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,565	0.00	711	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
200.00		Total (lines 30 through 199)		0	11,927		5,026	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	48,537,052	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,731,960	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,537,118	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	0	0	0	13,294,732	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	27,380,885	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,527,763	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	42,611,690	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,530,682	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	4,394,578	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	8,288,691	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,663,881	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,784,707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,161,945	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,435,519	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,868,981	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	47,538,589	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,840,420	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	3,495,800	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	318,624,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,215,023	0	9,334,396	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	104,548	0	296,967	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,372,623	0	6,269,915	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.000000	19,558	0	5,451,939	0	56.01
57.00	05700	CT SCAN	0.000000	2,450,808	0	6,403,664	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	491,057	0	3,241,759	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,657,151	0	4,376,214	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	2,476,608	0	185,934	0	65.00
65.01	06501	SLEEP LAB	0.000000	4,946	0	1,229,329	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	843,137	0	46,288	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,287,920	0	3,727,732	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,647,360	0	1,792,129	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	2,277,164	0	1,593,236	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,961,328	0	10,701,230	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	1,711	0	651,276	0	90.00
91.00	09100	EMERGENCY	0.000000	3,772,667	0	7,648,699	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	877,695	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	43,225	0	801,426	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		29,626,834	0	64,629,828	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 9:04 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	0.166902	9,334,396	0	0	1,557,929	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.199361	296,967	0	0	356,171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.271200	6,269,915	0	0	1,700,401	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.305674	5,451,939	0	0	1,666,516	56.01
57.00	05700	CT SCAN	0.054139	6,403,664	0	0	346,688	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.124792	3,241,759	0	0	404,546	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.181638	4,376,214	0	0	794,887	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.401186	185,934	0	0	74,594	65.00
65.01	06501	SLEEP LAB	0.237324	1,229,329	0	0	291,749	65.01
66.00	06600	PHYSICAL THERAPY	0.469907	46,288	0	0	21,751	66.00
69.00	06900	ELECTROCARDIOLOGY	0.240480	3,727,732	0	0	896,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265510	1,792,129	0	0	475,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262385	1,593,236	1,071	0	418,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354477	10,701,230	0	12,603	3,793,340	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.004220	651,276	0	0	654,024	90.00
91.00	09100	EMERGENCY	0.142860	7,648,699	0	0	1,092,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.462944	877,695	0	0	406,324	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.832730	801,426	0	0	667,371	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		64,629,828	1,071	12,603	15,619,298	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		64,629,828	1,071	12,603	15,619,298	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 9:04 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
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
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	ONCOLOGY	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	281	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,467		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	281	4,467		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	281	4,467		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 9:04 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)	10,362	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,362	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,744	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,315	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)	14,285,724	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)	14,285,724	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)	14,285,724	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,378.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,948,918	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,948,918	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,755,869	1,565	1,760.94	711	1,252,028	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)	7,189,560	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,390,506	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)	458,710	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	335,474	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	794,184	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,596,322	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)	618	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,378.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	852,012	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 9:04 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	928,056	14,285,724	0.064964	852,012	55,350	90.00
91.00	Nursing School cost	0	14,285,724	0.000000	852,012	0	91.00
92.00	Allied health cost	0	14,285,724	0.000000	852,012	0	92.00
93.00	All other Medical Education	0	14,285,724	0.000000	852,012	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,362	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,362	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,744	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)	277	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)	14,285,724	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)	14,285,724	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)	14,285,724	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,378.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	381,889	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)	381,889	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,755,869	1,565	1,760.94	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	285,825	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	667,714	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	618	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,378.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	852,012	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	928,056	14,285,724	0.064964	852,012	55,350	90.00
91.00	Nursing School cost	0	14,285,724	0.000000	852,012	0	91.00
92.00	Allied health cost	0	14,285,724	0.000000	852,012	0	92.00
93.00	All other Medical Education	0	14,285,724	0.000000	852,012	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/22/2018 9:04 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		5,467,517		30.00
31.00	03100	INTENSIVE CARE UNIT		1,989,019		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166902	3,215,023	536,594	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.281129	104,548	133,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.271200	1,372,623	372,255	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.306118	19,558	5,987	56.01
57.00	05700	CT SCAN	0.054139	2,450,808	132,684	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.124792	491,057	61,280	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.181638	4,657,151	845,916	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.401186	2,476,608	993,580	65.00
65.01	06501	SLEEP LAB	0.237324	4,946	1,174	65.01
66.00	06600	PHYSICAL THERAPY	0.470117	843,137	396,373	66.00
69.00	06900	ELECTROCARDIOLOGY	0.240480	1,287,920	309,719	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265510	1,647,360	437,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262385	2,277,164	597,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354477	4,961,328	1,758,677	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.040493	1,711	1,780	90.00
91.00	09100	EMERGENCY	0.150748	3,772,667	568,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.462944	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.832730	43,225	35,995	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		29,626,834	7,189,560	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)		29,626,834		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/22/2018 9:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		441,741		30.00
31.00	03100	INTENSIVE CARE UNIT		95,421		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166902	238,844	39,864	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.199361	28,314	33,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.271200	47,634	12,918	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	ONCOLOGY	0.305674	4	1	56.01
57.00	05700	CT SCAN	0.054139	91,676	4,963	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.124792	24,502	3,058	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.181638	218,917	39,764	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.401186	78,243	31,390	65.00
65.01	06501	SLEEP LAB	0.237324	91	22	65.01
66.00	06600	PHYSICAL THERAPY	0.469907	12,445	5,848	66.00
69.00	06900	ELECTROCARDIOLOGY	0.240480	13,085	3,147	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265510	114,036	30,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262385	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354477	227,413	80,613	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	1.004220	0	0	90.00
91.00	09100	EMERGENCY	0.142860	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.462944	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.832730	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,095,204	285,825	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,095,204		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/22/2018 9:04 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)	7,066,294	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,510,504	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)	248,147	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	44.31	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.89	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.38	31.00
32.00	Sum of lines 30 and 31	24.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.24	33.00
34.00	Disproportionate share adjustment (see instructions)	221,225	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/22/2018 9:04 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	0	35.00
35.01	Factor 3 (see instructions)	0.000052876	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	316,065	625,325	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	236,399	157,616	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	394,015		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,440,185		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,440,185	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	782,449	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)	11,222,634	59.00
60.00	Primary payer payments	4,403	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,218,231	61.00
62.00	Deductibles billed to program beneficiaries	1,232,896	62.00
63.00	Coinsurance billed to program beneficiaries	20,727	63.00
64.00	Allowable bad debts (see instructions)	291,931	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	189,755	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	36,258	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,154,363	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	84,179	70.93
70.94	HRR adjustment amount (see instructions)	-24,025	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/22/2018 9:04 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2017	88,618	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	15,285	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,318,420	71.00
71.01	Sequestration adjustment (see instructions)		206,368	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,991,891	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		120,161	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		159,521	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,066,294	0	7,066,294		7,066,294	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,510,504	0		2,510,504	2,510,504	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	248,147	0	227,569	20,578	248,147	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0924	0.0924	0.0924	0.0924		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	221,225	0	163,232	57,993	221,225	11.00
11.01	Uncompensated care payments	36.00	394,015	0	236,399	157,616	394,015	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,440,185	0	7,693,494	2,746,691	10,440,185	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,440,185	0	7,693,494	2,746,691	10,440,185	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	782,449	0	577,750	204,699	782,449	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,271,244	2,951,390	11,222,634	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	776,772	0	572,267	204,505	776,772	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,677	0	5,483	194	5,677	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	782,449	0	577,750	204,699	782,449	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.010714	0.005179		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			88,618		88,618	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				15,285	15,285	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,066,294	7,066,294		7,066,294	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,510,504		2,510,504	2,510,504	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	248,147	227,569	20,579	248,148	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0924	0.0924	0.0924		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	221,225	163,232	57,993	221,225	11.00
11.01	Uncompensated care payments	36.00	394,015	236,399	157,616	394,015	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,440,185	7,693,493	2,746,692	10,440,185	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,440,185	7,693,493	2,746,692	10,440,185	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	782,449	577,750	204,699	782,449	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,271,243	2,951,391	11,222,634	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	776,772	572,267	204,505	776,772	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,677	5,483	194	5,677	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	782,449	577,750	204,699	782,449	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	88,618	88,618		88,618	28.00
29.00	Low volume adjustment on or after October 1	70.97	15,285		15,285	15,285	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	84,179	63,506	20,673	84,179	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-24,025	-24,025	0	-24,025	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/22/2018 9:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,748	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,619,298	2.00
3.00	OPPS payments	11,147,644	3.00
4.00	Outlier payment (see instructions)	37,791	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,748	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,674	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)	13,674	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)	13,674	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,926	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,748	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	11,185,435	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	214	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,206,239	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)	8,983,730	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)	8,983,730	30.00
31.00	Primary payer payments	1,066	31.00
32.00	Subtotal (line 30 minus line 31)	8,982,664	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)	476,572	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	309,772	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	291,931	36.00
37.00	Subtotal (see instructions)	9,292,436	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	9,292,436	40.00
40.01	Sequestration adjustment (see instructions)	185,849	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	9,019,117	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	87,470	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: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2018 9:04 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		9,934,835		8,802,313	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2017	41,771	12/31/2017	216,804	3.01
3.02		12/31/2017	15,285		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)		57,056		216,804	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,991,891		9,019,117	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		120,161		87,470	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,112,052		9,106,587	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: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/22/2018 9:04 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2018 9:04 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	667,714		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	667,714	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	667,714	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	537,161		8.00
9.00	Ancillary service charges	1,095,204	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,632,365	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,632,365	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	964,651	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	667,714	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	667,714	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	667,714	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	667,714	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	667,714	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	667,714	0	40.00
41.00	Interim payments	788,561	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-120,847	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/22/2018 9:04 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	8,193,004	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	34,023,019	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,123,625	0	0	0	6.00
7.00	Inventory	2,439,550	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	10,184,042	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)	31,715,990	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,900,662	0	0	0	12.00
13.00	Land improvements	11,256,655	0	0	0	13.00
14.00	Accumulated depreciation	-2,843,124	0	0	0	14.00
15.00	Buildings	108,856,596	0	0	0	15.00
16.00	Accumulated depreciation	-9,246,260	0	0	0	16.00
17.00	Leasehold improvements	263,922	0	0	0	17.00
18.00	Accumulated depreciation	-236,542	0	0	0	18.00
19.00	Fixed equipment	6,087,593	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	47,933,556	0	0	0	23.00
24.00	Accumulated depreciation	-24,519,134	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	140,453,924	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	137,955,455	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	137,955,455	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	310,125,369	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,663,017	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,068,406	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,287,020	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,018,443	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	76,147,057	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	76,147,057	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	92,165,500	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	217,959,869				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)	217,959,869	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	310,125,369	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/22/2018 9:04 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		179,012,993		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		38,868,007				2.00
3.00	Total (sum of line 1 and line 2)		217,881,000		0		3.00
4.00	CONTRACTUALS REPORTED AS EXPENSE	78,869		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)		78,869		0		10.00
11.00	Subtotal (line 3 plus line 10)		217,959,869		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)		217,959,869		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	CONTRACTUALS REPORTED AS EXPENSE		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: 15-0097 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/22/2018 9:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,006,551		21,006,551	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	21,006,551		21,006,551	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,006,551		21,006,551	17.00
18.00	Ancillary services	54,756,014	205,634,131	260,390,145	18.00
19.00	Outpatient services	8,000,004	43,162,303	51,162,307	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		2,300,159	2,300,159	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RENOVO	0	1,463	1,463	27.00
27.01	MHCD	1,567,871	4,142,389	5,710,260	27.01
27.02	HOSPITALIST	2,528,394	927,269	3,455,663	27.02
27.03	OTHER NONREIMBURSABLE COST CENTERS	4,230	1,736,833	1,741,063	27.03
27.04	PROFESSIONAL FEES	1,569,060	2,673,528	4,242,588	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	89,432,124	260,578,075	350,010,199	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		117,334,718		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)		117,334,718		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/22/2018 9:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	350,010,199	1.00
2.00	Less contractual allowances and discounts on patients' accounts	234,770,949	2.00
3.00	Net patient revenues (line 1 minus line 2)	115,239,250	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	117,334,718	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,095,468	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,918,200	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	5,273,047	24.00
24.01	OTHER INCOME	-15,494	24.01
24.02	OTHER NON-OPERATING INCOME	27,787,722	24.02
25.00	Total other income (sum of lines 6-24)	40,963,475	25.00
26.00	Total (line 5 plus line 25)	38,868,007	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	38,868,007	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0097 HHA CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	221,467	59,151	33,007	0	51,520	365,145	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	493,688	0	0	0	0	493,688	6.00
7.00	Physical Therapy	392,690	28,399	18,141	34,933	3,505	477,668	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	1,448	0	0	0	0	1,448	9.00
10.00	Medical Social Services	3,614	0	0	0	0	3,614	10.00
11.00	Home Health Aide	58,303	0	0	0	0	58,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	32,849	32,849	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,171,210	87,550	51,148	34,933	87,874	1,432,715	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	365,145	-560	364,585			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	493,688	0	493,688			6.00
7.00	Physical Therapy	0	477,668	0	477,668			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	1,448	0	1,448			9.00
10.00	Medical Social Services	0	3,614	0	3,614			10.00
11.00	Home Health Aide	0	58,303	0	58,303			11.00
12.00	Supplies (see instructions)	0	32,849	0	32,849			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,432,715	-560	1,432,155			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0097 HHA CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	364,585	0	0	0	0	364,585	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	493,688	0	0	0	0	493,688	6.00
7.00	Physical Therapy	477,668	0	0	0	0	477,668	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	1,448	0	0	0	0	1,448	9.00
10.00	Medical Social Services	3,614	0	0	0	0	3,614	10.00
11.00	Home Health Aide	58,303	0	0	0	0	58,303	11.00
12.00	Supplies (see instructions)	32,849	0	0	0	0	32,849	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,432,155	0	0	0	0	1,432,155	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	364,585			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	168,599	662,287		6.00
7.00	Physical Therapy	163,128	640,796		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	495	1,943		9.00
10.00	Medical Social Services	1,234	4,848		10.00
11.00	Home Health Aide	19,911	78,214		11.00
12.00	Supplies (see instructions)	11,218	44,067		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		1,432,155		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0097
HHA CCN: 15-7418

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

Worksheet H-1 Part II
Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I

PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-364,585	1,067,570	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	493,688	6.00
7.00	Physical Therapy	0	0	0	0	0	477,668	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	1,448	9.00
10.00	Medical Social Services	0	0	0	0	0	3,614	10.00
11.00	Home Health Aide	0	0	0	0	0	58,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	32,849	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-364,585	1,067,570	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		364,585	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.341509	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0097 HHA CCN: 15-7418

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

Worksheet H-2 Part I Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	175,022	304,921	479,943	129,291	110,938	1.00
2.00	Skilled Nursing Care	662,287	0	0	662,287	178,414	0	2.00
3.00	Physical Therapy	640,796	0	0	640,796	172,623	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	1,943	0	0	1,943	523	0	5.00
6.00	Medical Social Services	4,848	0	0	4,848	1,306	0	6.00
7.00	Home Health Aide	78,214	0	0	78,214	21,070	0	7.00
8.00	Supplies (see instructions)	44,067	0	0	44,067	11,871	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,432,155	175,022	304,921	1,912,098	515,098	110,938	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	84,604	0	0	74,762	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	84,604	0	0	74,762	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0097 HHA CCN: 15-7418

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

Worksheet H-2 Part I Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I

PPS

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	12,642	892,180	0	892,180		1.00
2.00	Skilled Nursing Care	0	0	840,701	0	840,701	412,582	2.00
3.00	Physical Therapy	0	0	813,419	0	813,419	399,192	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	2,466	0	2,466	1,210	5.00
6.00	Medical Social Services	0	0	6,154	0	6,154	3,020	6.00
7.00	Home Health Aide	0	0	99,284	0	99,284	48,724	7.00
8.00	Supplies (see instructions)	0	0	55,938	0	55,938	27,452	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	12,642	2,710,142	0	2,710,142	892,180	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.490758	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	1,253,283	2.00
3.00	Physical Therapy	1,212,611	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	3,676	5.00
6.00	Medical Social Services	9,174	6.00
7.00	Home Health Aide	148,008	7.00
8.00	Supplies (see instructions)	83,390	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,710,142	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0097 HHA CCN: 15-7418

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

Worksheet H-2 Part II Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	6,391	1,171,210	0	479,943	6,391	0	1.00
2.00	Skilled Nursing Care	0	0	0	662,287	0	0	2.00
3.00	Physical Therapy	0	0	0	640,796	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	1,943	0	0	5.00
6.00	Medical Social Services	0	0	0	4,848	0	0	6.00
7.00	Home Health Aide	0	0	0	78,214	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	44,067	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	6,391	1,171,210		1,912,098	6,391	0	20.00
21.00	Total cost to be allocated	175,022	304,921		515,098	110,938	0	21.00
22.00	Unit cost multiplier	27.385699	0.260347		0.269389	17.358473	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	6,391	0	0	32,866	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	6,391	0	0	32,866	0	0	20.00
21.00	Total cost to be allocated	84,604	0	0	74,762	0	0	21.00
22.00	Unit cost multiplier	13.237991	0.000000	0.000000	2.274752	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0097
HHA CCN: 15-7418

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

Worksheet H-2
Part II
Date/Time Prepared:
5/22/2018 9:04 pm

Home Health Agency I

PPS

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)										
		16.00										
1.00	Administrative and General	2,300,159										1.00
2.00	Skilled Nursing Care	0										2.00
3.00	Physical Therapy	0										3.00
4.00	Occupational Therapy	0										4.00
5.00	Speech Pathology	0										5.00
6.00	Medical Social Services	0										6.00
7.00	Home Health Aide	0										7.00
8.00	Supplies (see instructions)	0										8.00
9.00	Drugs	0										9.00
10.00	DME	0										10.00
11.00	Home Dialysis Aide Services	0										11.00
12.00	Respiratory Therapy	0										12.00
13.00	Private Duty Nursing	0										13.00
14.00	Clinic	0										14.00
15.00	Health Promotion Activities	0										15.00
16.00	Day Care Program	0										16.00
17.00	Home Delivered Meals Program	0										17.00
18.00	Homemaker Service	0										18.00
19.00	All Others (specify)	0										19.00
19.50	Telemedicine	0										19.50
20.00	Total (sum of lines 1-19)	2,300,159										20.00
21.00	Total cost to be allocated	12,642										21.00
22.00	Unit cost multiplier	0.005496										22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,253,283		1,253,283	5,756	217.74	1.00
2.00	Physical Therapy	3.00	1,212,611	0	1,212,611	4,564	265.69	2.00
3.00	Occupational Therapy	4.00	0	0	0	0	0.00	3.00
4.00	Speech Pathology	5.00	3,676	0	3,676	32	114.88	4.00
5.00	Medical Social Services	6.00	9,174		9,174	87	105.45	5.00
6.00	Home Health Aide	7.00	148,008		148,008	1,063	139.24	6.00
7.00	Total (sum of lines 1-6)		2,626,752	0	2,626,752	11,502		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		26900	0	3,138			8.00
9.00	Physical Therapy		26900	0	2,737			9.00
10.00	Occupational Therapy		26900	0	0			10.00
11.00	Speech Pathology		26900	0	12			11.00
12.00	Medical Social Services		26900	0	41			12.00
13.00	Home Health Aide		26900	0	924			13.00
14.00	Total (sum of lines 8-13)			0	6,852			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	83,390	0	83,390	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,138		0	683,268		1.00
2.00	Physical Therapy	0	2,737		0	727,194		2.00
3.00	Occupational Therapy	0	0		0	0		3.00
4.00	Speech Pathology	0	12		0	1,379		4.00
5.00	Medical Social Services	0	41		0	4,323		5.00
6.00	Home Health Aide	0	924		0	128,658		6.00
7.00	Total (sum of lines 1-6)	0	6,852		0	1,544,822		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Home Health Agency I | PPS

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	683,268	1.00
2.00	Physical Therapy	727,194	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	1,379	4.00
5.00	Medical Social Services	4,323	5.00
6.00	Home Health Aide	128,658	6.00
7.00	Total (sum of lines 1-6)	1,544,822	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0097
HHA CCN: 15-7418

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

Worksheet H-3
Part II
Date/Time Prepared:
5/22/2018 9:04 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.469907	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.265510	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.354477	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0097 | HHA CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/22/2018 9:04 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	956,062	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	64,111	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,081	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,236	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	14,631	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,048,121	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,048,121	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,048,121	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,048,121	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,048,121	31.00
31.01	Sequestration adjustment (see instructions)	0	20,962	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,027,158	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-0097 HHA CCN: 15-7418 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 Date/Time Prepared: 5/22/2018 9:04 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,027,158	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,027,158	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,027,159	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0097	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/22/2018 9:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	776,772	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,677	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)	31.08	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)	782,449	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