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: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 12:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2018 Time: 12:02 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL LOGANSPORT (15-0072) 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	39,754	115,950	0	-119,516	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	39,754	115,950	0	-119,516	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1101 MICHIGAN AVENUE	PO Box:			1.00
2.00	City: LOGANSPORT	State: IN	Zip Code: 46947-	County: CASS	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	MEMORIAL HOSPITAL LOGANSPORT	150072	99915	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	SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	320	0	0	0	1,445	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	01/01/2017	12/31/2017	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2018 12:00 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 pm

		1.00	2.00	3.00	
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 pm

		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

		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:	569,860	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 pm

		1.00	2.00	
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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 12:00 pm

		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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2018 12:00 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/06/2018	Y	04/06/2018	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 12:00 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.				N	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.	MICHAEL		ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 12:00 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 12:00 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		83	30,295	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		83				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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 12:00 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)	1,875	213	4,263			1.00
2.00	HMO and other (see instructions)	379	1,445				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)	1,875	213	4,263			7.00
8.00	INTENSIVE CARE UNIT	264	0	510			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		107	1,113			13.00
14.00	Total (see instructions)	2,139	320	5,886	0.00	499.99	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	499.99	27.00
28.00	Observation Bed Days		10	1,168			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	182			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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 12:00 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	707	132	1,786	1.00
2.00	HMO and other (see instructions)			111	640		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	707	132	1,786	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2018 12:00 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	31,575,971	0	31,575,971	1,039,983.00	30.36	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,483,926	0	3,483,926	38,710.00	90.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,536,856	0	7,536,856	166,779.00	45.19	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		187,290	0	187,290	1,863.00	100.53	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)		5,782,122	0	5,782,122			17.00
18.00	Wage-related costs (other) (see instructions)		675,379	0	675,379			18.00
19.00	Excluded areas		1,460,480	0	1,460,480			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		407,090	0	407,090			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 5/30/2018 12:00 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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	309,169	0	309,169	10,400.00	29.73	26.00
27.00	Administrative & General	5.00	3,625,878	0	3,625,878	151,096.00	24.00	27.00
28.00	Administrative & General under contract (see inst.)		146,916	0	146,916	842.00	174.48	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	596,348	0	596,348	23,120.00	25.79	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	508,805	0	508,805	40,677.00	12.51	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	606,312	-423,717	182,595	17,072.00	10.70	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	423,717	423,717	34,353.00	12.33	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	558,470	0	558,470	13,808.00	40.45	38.00
39.00	Central Services and Supply	14.00	220,480	0	220,480	14,013.00	15.73	39.00
40.00	Pharmacy	15.00	430,855	0	430,855	20,996.00	20.52	40.00
41.00	Medical Records & Medical Records Library	16.00	613,353	0	613,353	29,758.00	20.61	41.00
42.00	Social Service	17.00	336,963	0	336,963	11,741.00	28.70	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2018 12:00 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)		28,238,961	0	28,238,961	1,002,115.00	28.18	1.00
2.00	Excluded area salaries (see instructions)		7,536,856	0	7,536,856	166,779.00	45.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)		20,702,105	0	20,702,105	835,336.00	24.78	3.00
4.00	Subtotal other wages & related costs (see inst.)		187,290	0	187,290	1,863.00	100.53	4.00
5.00	Subtotal wage-related costs (see inst.)		6,457,501	0	6,457,501	0.00	31.19	5.00
6.00	Total (sum of lines 3 thru 5)		27,346,896	0	27,346,896	837,199.00	32.66	6.00
7.00	Total overhead cost (see instructions)		7,953,549	0	7,953,549	367,876.00	21.62	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2018 12:00 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	327,939	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	4,467,805	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	133,404	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	46,479	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)	306,097	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	272,741	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,041,083	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,331	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	31,813	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,649,692	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	675,379	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2018 12:00 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	7,649,692	1.00
2.00	Hospital	0	7,649,692	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/30/2018 12:00 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)	0.307907	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,563,921	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	25,543,150	6.00
7.00	Medicaid cost (line 1 times line 6)	7,864,915	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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)	647,590	781,302	1,428,892	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	199,397	781,302	980,699	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)	199,397	781,302	980,699	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,795,970	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	161,756	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	248,855	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,547,115	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,410,909	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,391,608	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,391,608	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		4,479,085	4,479,085	-251,304	4,227,781	1.00
1.01	00101	MOB		226,553	226,553	0	226,553	1.01
1.02	00102	OPS		147,326	147,326	0	147,326	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	309,169	8,501,174	8,810,343	0	8,810,343	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,625,878	5,142,259	8,768,137	395,931	9,164,068	5.00
7.00	00700	OPERATION OF PLANT	596,348	2,157,337	2,753,685	0	2,753,685	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	169,516	169,516	0	169,516	8.00
9.00	00900	HOUSEKEEPING	508,805	207,385	716,190	0	716,190	9.00
10.00	01000	DIETARY	606,312	595,336	1,201,648	-839,764	361,884	10.00
11.00	01100	CAFETERIA	0	0	0	839,764	839,764	11.00
13.00	01300	NURSING ADMINISTRATION	558,470	8,973	567,443	0	567,443	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	220,480	549,090	769,570	0	769,570	14.00
15.00	01500	PHARMACY	430,855	510,090	940,945	0	940,945	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	613,353	259,316	872,669	0	872,669	16.00
17.00	01700	SOCIAL SERVICE	336,963	10,838	347,801	0	347,801	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,451,643	1,205,719	4,657,362	-1,005,456	3,651,906	30.00
31.00	03100	INTENSIVE CARE UNIT	592,332	42,022	634,354	0	634,354	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
43.00	04300	NURSERY	0	5,438	5,438	303,057	308,495	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,430,028	574,126	2,004,154	0	2,004,154	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	836	836	702,399	703,235	52.00
53.00	05300	ANESTHESIOLOGY	0	779,026	779,026	0	779,026	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,111,214	568,503	1,679,717	0	1,679,717	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,677,582	2,677,582	0	2,677,582	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	108,859	108,859	0	108,859	63.00
65.00	06500	RESPIRATORY THERAPY	654,294	166,243	820,537	0	820,537	65.00
66.00	06600	PHYSICAL THERAPY	64,064	836,750	900,814	0	900,814	66.00
69.00	06900	ELECTROCARDIOLOGY	356,440	160,693	517,133	0	517,133	69.00
69.01	06901	CARDIAC REHAB	182,289	-1,202	181,087	0	181,087	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,694,203	1,694,203	-948,033	746,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	948,033	948,033	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,388,894	2,388,894	0	2,388,894	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	211,910	171,002	382,912	0	382,912	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,758,806	934,766	7,693,572	0	7,693,572	90.00
90.01	09001	WOUND CARE	14,737	165,066	179,803	0	179,803	90.01
91.00	09100	EMERGENCY	1,404,725	927,467	2,332,192	0	2,332,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,039,115	36,370,271	60,409,386	144,627	60,554,013	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	4,620	4,620	0	4,620	194.00
194.01	07951	MOB	0	3	3	0	3	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	547,943	214,230	762,173	-64	762,109	194.04
194.05	07955	PHYSICIANS OFFICE	6,652,969	2,431,711	9,084,680	-138,260	8,946,420	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	308,023	6,764	314,787	-6,303	308,484	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	27,921	68,428	96,349	0	96,349	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	31,575,971	39,096,027	70,671,998	0	70,671,998	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-31,505	4,196,276		1.00
1.01	00101	MOB	0	226,553		1.01
1.02	00102	OPS	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,276	8,804,067		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,732,610	6,431,458		5.00
7.00	00700	OPERATION OF PLANT	-11,861	2,741,824		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	169,516		8.00
9.00	00900	HOUSEKEEPING	0	716,190		9.00
10.00	01000	DIETARY	-25,251	336,633		10.00
11.00	01100	CAFETERIA	-320,448	519,316		11.00
13.00	01300	NURSING ADMINISTRATION	0	567,443		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-27,361	742,209		14.00
15.00	01500	PHARMACY	0	940,945		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30,487	842,182		16.00
17.00	01700	SOCIAL SERVICE	0	347,801		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,530,164	2,121,742		30.00
31.00	03100	INTENSIVE CARE UNIT	0	634,354		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	308,495		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,004,154		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	703,235		52.00
53.00	05300	ANESTHESIOLOGY	-709,035	69,991		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,679,717		54.00
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	2,677,582		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	108,859		63.00
65.00	06500	RESPIRATORY THERAPY	-6,000	814,537		65.00
66.00	06600	PHYSICAL THERAPY	0	900,814		66.00
69.00	06900	ELECTROCARDIOLOGY	0	517,133		69.00
69.01	06901	CARDIAC REHAB	0	181,087		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	746,170		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	948,033		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,388,894		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	382,912		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,695,587	2,997,985		90.00
90.01	09001	WOUND CARE	-133,054	46,749		90.01
91.00	09100	EMERGENCY	-752,281	1,579,911		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,011,920	49,542,093		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	FOUNDATION	0	4,620		194.00
194.01	07951	MOB	0	3		194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0		194.02
194.03	07953	PIH	0	0		194.03
194.04	07954	HEALTH COMPANIES	0	762,109		194.04
194.05	07955	PHYSICIANS OFFICE	0	8,946,420		194.05
194.06	07956	THE ARBORS	0	0		194.06
194.07	07957	PAIN MANAGEMENT	0	308,484		194.07
194.08	07958	OPS	0	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	96,349		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,011,920	59,660,078		200.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 12:00 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	423,717	416,047		1.00
	0		423,717	416,047		
	B - OB RECLASS					
1.00	NURSERY	43.00	273,097	29,960		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	622,543	79,856		2.00
	0		895,640	109,816		
	C - MALPRACTICE INS. RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	395,931		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	395,931		
	D - IMPLANT EXPENSE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	948,033		1.00
	0		0	948,033		
500.00	Grand Total: Increases		1,319,357	1,869,827		500.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 12:00 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	423,717	416,047	0		1.00
	0		423,717	416,047			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	895,640	109,816	0		1.00
2.00		0.00	0	0	0		2.00
	0		895,640	109,816			
	C - MALPRACTICE INS. RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	251,304	12		1.00
2.00	HEALTH COMPANIES	194.04	0	64	0		2.00
3.00	PHYSICIANS OFFICE	194.05	0	138,260	0		3.00
4.00	PAIN MANAGEMENT	194.07	0	6,303	0		4.00
	0		0	395,931			
	D - IMPLANT EXPENSE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	948,033	0		1.00
	0		0	948,033			
500.00	Grand Total: Decreases		1,319,357	1,869,827			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2018 12:00 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	205,783	0	0	0	0	1.00
2.00	Land Improvements	566,240	126,130	0	126,130	0	2.00
3.00	Buildings and Fixtures	60,371,036	452,470	0	452,470	0	3.00
4.00	Building Improvements	2,602,264	5,469,549	0	5,469,549	2,027,187	4.00
5.00	Fixed Equipment	39,074,336	3,563,769	0	3,563,769	139,456	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	102,819,659	9,611,918	0	9,611,918	2,166,643	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	102,819,659	9,611,918	0	9,611,918	2,166,643	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	205,783	0	1.00
2.00	Land Improvements	692,370	0	2.00
3.00	Buildings and Fixtures	60,823,506	0	3.00
4.00	Building Improvements	6,044,626	0	4.00
5.00	Fixed Equipment	42,498,649	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	110,264,934	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	110,264,934	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2018 12:00 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,631,633	0	505,496	341,956	0	1.00
1.01	MOB	226,553	0	0	0	0	1.01
1.02	OPS	147,326	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	4,005,512	0	505,496	341,956	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,479,085		1.00
1.01	MOB	0	226,553		1.01
1.02	OPS	0	147,326		1.02
3.00	Total (sum of lines 1-2)	0	4,852,964		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2018 12:00 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	NEW CAP REL COSTS-BLDG & FIXT	4,479,085	0	4,479,085	0.922959	0	1.00
1.01	MOB	226,553	0	226,553	0.046683	0	1.01
1.02	OPS	147,326	0	147,326	0.030358	0	1.02
3.00	Total (sum of lines 1-2)	4,852,964	0	4,852,964	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,604,743	0	1.00
1.01	MOB	0	0	0	226,553	0	1.01
1.02	OPS	0	0	0	147,326	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	3,978,622	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	505,496	86,037	0	0	4,196,276	1.00
1.01	MOB	0	0	0	0	226,553	1.01
1.02	OPS	0	0	0	0	147,326	1.02
3.00	Total (sum of lines 1-2)	505,496	86,037	0	0	4,570,155	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 12:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - OPS (chapter 2)		0	OPS	1.02	0	1.02
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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,443,153			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	A	-320,448	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - OPS		0	OPS	1.02	0	26.02
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 12:00 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	
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	OTHER REVENUE - VENDING COMMISSION	B	-7,005	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE - CASH OVER/SHORT	B	148	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER REVENUE - MISCELLANEOUS	B	-1,209	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER REVENUE - NON PAT REBATES	B	-28	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER REVENUE - BAD DEBT	B	-327	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER REVENUE - MEDICARE	B	93	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHER REVENUE - BLUE CROSS	B	-1,894	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	OTHER REVENUE - MEDICAID	B	-1,337	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER REVENUE - SCRAP SAL	B	-6,082	ADMINISTRATIVE & GENERAL	5.00	0	41.00
44.00	OTHER REVENUE - CASH OVER	B	275	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MHL A/P DISCOUNTS	B	38	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MHL TELEPHONE SERVICE	B	-9,591	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MEALS ON WHEELS	B	-24,716	DIETARY	10.00	0	45.02
45.03	OTHER REVENEU - NUTRITIONALS	B	-243	DIETARY	10.00	0	45.03
45.04	OTHER REVENUE - REBATES	B	-292	DIETARY	10.00	0	45.04
45.05	OTHER REVENUE - REBATES MMT	B	-27,361	CENTRAL SERVICES & SUPPLY	14.00	0	45.05
45.06	HIM MEDICAL RECORDS FEES	B	-30,487	MEDICAL RECORDS & LIBRARY	16.00	0	45.06
45.07	OTHER REVENUE - CPR TRAINING	B	-2,178	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08	OTHER REVENUE - ACLS REVENUE	B	-1,045	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.08
45.09	INTEREST INCOME	B	-4,615	NEW CAP REL COSTS-BLDG & FIXT	1.00	12	45.09
45.10	PATIENT TELEVISIONS	A	-560	OPERATION OF PLANT	7.00	0	45.10
45.11	PATIENT TELEVISIONS	A	-1,006	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.11
45.12	PATIENT TELEPHONES	A	-3,053	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.12
45.13	PATIENT TELEPHONES	A	-3,394	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.14	PATIENT TELEPHONES	A	-1,921	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	IHA & AHA LOBBYING FEES	A	-6,317	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	GIFT SHOP	A	-13,606	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.16
45.17	GIFT SHOP	A	-9,376	OPERATION OF PLANT	7.00	0	45.17
45.18	ADVERTISING	A	-587,893	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	TAXES	A	-67,089	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	DONATION EXPENSE	A	-24,131	ADMINISTRATIVE & GENERAL	5.00	0	45.20
45.21	PHYSICIAN RECRUITMENT	A	-225,164	ADMINISTRATIVE & GENERAL	5.00	0	45.21
45.22	CAPITALIZED INTEREST	A	-6,091	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.22
45.23	VENDING	A	-1,925	OPERATION OF PLANT	7.00	0	45.23
45.24	VENDING	A	-2,793	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.24
45.25	HOSPITAL ASSESSMENT FEE OFFSET	A	-1,793,176	ADMINISTRATIVE & GENERAL	5.00	0	45.25
45.26	HOSPITALIST	A	-382,968	ADULTS & PEDIATRICS	30.00	0	45.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,011,920				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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2018 12:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,147,196	1,147,196	0	237,100	0	1.00
2.00	53.00	ANESTHESIOLOGY	709,035	709,035	0	239,400	0	2.00
3.00	65.00	RESPIRATORY THERAPY	6,000	6,000	0	179,000	0	3.00
4.00	90.00	CLINIC	4,769,859	4,673,693	96,166	179,000	806	4.00
5.00	90.01	WOUND CARE	133,054	133,054	0	179,000	0	5.00
6.00	91.00	EMERGENCY	752,281	752,281	0	246,400	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,517,425	7,421,259	96,166		806	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	69,363	3,468	69,553	1,402	173,929	4.00
5.00	90.01	WOUND CARE	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			69,363	3,468	69,553	1,402	173,929	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,147,196		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	709,035		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	6,000		3.00
4.00	90.00	CLINIC	3,507	74,272	21,894	4,695,587		4.00
5.00	90.01	WOUND CARE	0	0	0	133,054		5.00
6.00	91.00	EMERGENCY	0	0	0	752,281		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			3,507	74,272	21,894	7,443,153		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	MOB	OPS		
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,196,276	4,196,276				1.00
1.01	00101	MOB	226,553	0	226,553			1.01
1.02	00102	OPS	147,326	0	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,804,067	35,192	0	0	8,839,259	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,431,458	302,729	20,678	0	1,025,050	5.00
7.00	00700	OPERATION OF PLANT	2,741,824	745,444	1,339	17,398	168,590	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	169,516	13,173	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716,190	29,492	715	642	143,841	9.00
10.00	01000	DIETARY	336,633	120,986	0	0	51,620	10.00
11.00	01100	CAFETERIA	519,316	60,335	0	0	119,786	11.00
13.00	01300	NURSING ADMINISTRATION	567,443	46,803	0	0	157,882	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	742,209	87,124	0	0	62,331	14.00
15.00	01500	PHARMACY	940,945	44,396	0	0	121,804	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	842,182	157,170	0	0	173,397	16.00
17.00	01700	SOCIAL SERVICE	347,801	30,062	0	0	95,261	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,121,742	623,655	0	0	722,592	30.00
31.00	03100	INTENSIVE CARE UNIT	634,354	111,528	0	0	167,455	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
43.00	04300	NURSERY	308,495	19,042	0	0	77,206	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,004,154	411,386	0	0	404,275	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	703,235	104,477	0	0	175,995	52.00
53.00	05300	ANESTHESIOLOGY	69,991	37,218	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,679,717	190,588	0	12,351	314,145	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,677,582	102,113	6,772	5,760	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	108,859	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	814,537	7,262	0	0	184,972	65.00
66.00	06600	PHYSICAL THERAPY	900,814	80,643	0	0	18,111	66.00
69.00	06900	ELECTROCARDIOLOGY	517,133	10,112	14,249	0	100,767	69.00
69.01	06901	CARDIAC REHAB	181,087	117,439	0	0	51,534	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,170	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	948,033	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,388,894	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	382,912	15,474	22,063	0	59,908	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,997,985	4,433	85,360	0	1,910,751	90.00
90.01	09001	WOUND CARE	46,749	0	13,785	0	4,166	90.01
91.00	09100	EMERGENCY	1,579,911	323,438	0	0	397,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,542,093	3,831,714	164,961	36,151	6,708,560	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	4,620	0	0	0	0	194.00
194.01	07951	MOB	3	0	43,597	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	762,109	48,238	0	0	154,906	194.04
194.05	07955	PHYSICIANS OFFICE	8,946,420	95,083	17,995	49,888	1,880,821	194.05
194.06	07956	THE ARBORS	0	221,241	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	308,484	0	0	0	87,079	194.07
194.08	07958	OPS	0	0	0	61,287	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	96,349	0	0	0	7,893	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	59,660,078	4,196,276	226,553	147,326	8,839,259	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,779,915	7,779,915				5.00
7.00	00700	OPERATION OF PLANT	3,674,595	551,039	4,225,634			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	182,689	27,396	12,895	222,980		8.00
9.00	00900	HOUSEKEEPING	890,880	133,595	33,478	0	1,057,953	9.00
10.00	01000	DIETARY	509,239	76,365	118,433	0	0	10.00
11.00	01100	CAFETERIA	699,437	104,887	59,061	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	772,128	115,788	45,815	0	3,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	891,664	133,713	85,286	0	47,960	14.00
15.00	01500	PHARMACY	1,107,145	166,026	43,459	0	7,494	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,172,749	175,864	153,853	0	3,997	16.00
17.00	01700	SOCIAL SERVICE	473,124	70,949	29,427	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,467,989	520,056	610,492	57,887	352,540	30.00
31.00	03100	INTENSIVE CARE UNIT	913,337	136,963	109,175	6,380	53,289	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
43.00	04300	NURSERY	404,743	60,695	18,640	14,495	2,165	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,819,815	422,857	402,704	72,859	111,574	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	983,707	147,516	102,272	0	11,657	52.00
53.00	05300	ANESTHESIOLOGY	107,209	16,077	36,433	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,196,801	329,430	218,783	15,296	53,289	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,792,227	418,720	142,776	0	23,314	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	108,859	16,324	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,006,771	150,974	7,109	0	29,975	65.00
66.00	06600	PHYSICAL THERAPY	999,568	149,894	78,941	1,241	11,657	66.00
69.00	06900	ELECTROCARDIOLOGY	642,261	96,313	68,381	0	29,975	69.00
69.01	06901	CARDIAC REHAB	350,060	52,495	114,961	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,170	111,895	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	948,033	142,166	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,388,894	358,236	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	480,357	72,034	105,703	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,998,529	749,574	354,699	0	48,626	90.00
90.01	09001	WOUND CARE	64,700	9,702	56,582	0	0	90.01
91.00	09100	EMERGENCY	2,300,470	344,976	316,613	54,822	96,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,874,065	5,862,519	3,325,971	222,980	887,429	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	4,620	693	0	0	10,658	194.00
194.01	07951	MOB	43,600	6,538	178,941	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	965,253	144,748	47,220	0	13,322	194.04
194.05	07955	PHYSICIANS OFFICE	10,990,207	1,648,099	297,063	0	76,603	194.05
194.06	07956	THE ARBORS	221,241	33,177	216,572	0	43,297	194.06
194.07	07957	PAIN MANAGEMENT	395,563	59,318	0	0	0	194.07
194.08	07958	OPS	61,287	9,191	159,867	0	26,644	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	104,242	15,632	0	0	0	194.09
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)	59,660,078	7,779,915	4,225,634	222,980	1,057,953	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
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	704,037					10.00
11.00	01100	CAFETERIA	0	863,385				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,297	955,359			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,569	0	1,177,192		14.00
15.00	01500	PHARMACY	0	27,823	0	0	1,351,947	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,558	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	404,385	111,253	341,753	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	46,366	28,427	87,323	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
43.00	04300	NURSERY	0	11,867	36,452	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	67,003	205,823	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,051	83,098	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,451	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	33,490	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,595	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,167	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	8,894	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,177,192	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	1,351,947	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	8,287	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	229,185	0	0	0	90.00
90.01	09001	WOUND CARE	0	673	0	0	0	90.01
91.00	09100	EMERGENCY	0	65,405	200,910	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	450,751	750,995	955,359	1,177,192	1,351,947	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	26,183	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	86,207	0	0	0	194.05
194.06	07956	THE ARBORS	253,286	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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)	704,037	863,385	955,359	1,177,192	1,351,947	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
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	1,506,463					16.00
17.00	01700	SOCIAL SERVICE	0	589,058				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	106,149	443,767	6,416,271	0	6,416,271	30.00
31.00	03100	INTENSIVE CARE UNIT	12,619	52,845	1,446,724	0	1,446,724	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
43.00	04300	NURSERY	14,103	30,197	593,357	0	593,357	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	275,893	0	4,378,528	0	4,378,528	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,149	0	1,387,450	0	1,387,450	52.00
53.00	05300	ANESTHESIOLOGY	18,857	0	178,576	0	178,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,131	0	2,995,181	0	2,995,181	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	185,331	0	3,562,368	0	3,562,368	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,462	0	134,645	0	134,645	63.00
65.00	06500	RESPIRATORY THERAPY	60,145	0	1,288,464	0	1,288,464	65.00
66.00	06600	PHYSICAL THERAPY	34,376	0	1,281,272	0	1,281,272	66.00
69.00	06900	ELECTROCARDIOLOGY	36,908	0	894,005	0	894,005	69.00
69.01	06901	CARDIAC REHAB	5,974	0	532,384	0	532,384	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,035,257	0	2,035,257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,090,199	0	1,090,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,099,077	0	4,099,077	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	99,690	0	766,071	0	766,071	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	147,125	0	6,527,738	0	6,527,738	90.00
90.01	09001	WOUND CARE	3,233	0	134,890	0	134,890	90.01
91.00	09100	EMERGENCY	133,374	62,249	3,575,405	0	3,575,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,303,519	589,058	43,317,862	0	43,317,862	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	15,971	0	15,971	194.00
194.01	07951	MOB	0	0	229,079	0	229,079	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	1,196,726	0	1,196,726	194.04
194.05	07955	PHYSICIANS OFFICE	200,929	0	13,299,108	0	13,299,108	194.05
194.06	07956	THE ARBORS	0	0	767,573	0	767,573	194.06
194.07	07957	PAIN MANAGEMENT	2,015	0	456,896	0	456,896	194.07
194.08	07958	OPS	0	0	256,989	0	256,989	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	119,874	0	119,874	194.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,506,463	589,058	59,660,078	0	59,660,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MOB	CAPITAL RELATED COSTS OPS	CAPITAL RELATED COSTS Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	35,192	0	0	35,192	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	302,729	20,678	0	323,407	5.00
7.00	00700	OPERATION OF PLANT	0	745,444	1,339	17,398	764,181	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,173	0	0	13,173	8.00
9.00	00900	HOUSEKEEPING	0	29,492	715	642	30,849	9.00
10.00	01000	DIETARY	0	120,986	0	0	120,986	10.00
11.00	01100	CAFETERIA	0	60,335	0	0	60,335	11.00
13.00	01300	NURSING ADMINISTRATION	0	46,803	0	0	46,803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87,124	0	0	87,124	14.00
15.00	01500	PHARMACY	0	44,396	0	0	44,396	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	157,170	0	0	157,170	16.00
17.00	01700	SOCIAL SERVICE	0	30,062	0	0	30,062	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	623,655	0	0	623,655	30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,528	0	0	111,528	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
43.00	04300	NURSERY	0	19,042	0	0	19,042	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	411,386	0	0	411,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	104,477	0	0	104,477	52.00
53.00	05300	ANESTHESIOLOGY	0	37,218	0	0	37,218	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	190,588	0	12,351	202,939	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	102,113	6,772	5,760	114,645	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,262	0	0	7,262	65.00
66.00	06600	PHYSICAL THERAPY	0	80,643	0	0	80,643	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,112	14,249	0	24,361	69.00
69.01	06901	CARDIAC REHAB	0	117,439	0	0	117,439	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	15,474	22,063	0	37,537	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,433	85,360	0	89,793	90.00
90.01	09001	WOUND CARE	0	0	13,785	0	13,785	90.01
91.00	09100	EMERGENCY	0	323,438	0	0	323,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,831,714	164,961	36,151	4,032,826	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	43,597	0	43,597	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	48,238	0	0	48,238	194.04
194.05	07955	PHYSICIANS OFFICE	0	95,083	17,995	49,888	162,966	194.05
194.06	07956	THE ARBORS	0	221,241	0	0	221,241	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	61,287	61,287	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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	4,196,276	226,553	147,326	4,570,155	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	35,192					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,083	327,490				5.00
7.00	00700	OPERATION OF PLANT	671	23,194	788,046			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,153	2,405	16,731		8.00
9.00	00900	HOUSEKEEPING	573	5,623	6,243	0	43,288	9.00
10.00	01000	DIETARY	206	3,214	22,087	0	0	10.00
11.00	01100	CAFETERIA	477	4,415	11,014	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	629	4,874	8,544	0	136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	248	5,628	15,905	0	1,962	14.00
15.00	01500	PHARMACY	485	6,988	8,105	0	307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	691	7,402	28,692	0	164	16.00
17.00	01700	SOCIAL SERVICE	379	2,986	5,488	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,878	21,890	113,852	4,343	14,426	30.00
31.00	03100	INTENSIVE CARE UNIT	667	5,765	20,360	479	2,180	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
43.00	04300	NURSERY	308	2,555	3,476	1,088	89	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,610	17,799	75,101	5,467	4,565	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	701	6,209	19,073	0	477	52.00
53.00	05300	ANESTHESIOLOGY	0	677	6,794	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,251	13,866	40,801	1,148	2,180	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	17,625	26,627	0	954	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	687	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	737	6,355	1,326	0	1,226	65.00
66.00	06600	PHYSICAL THERAPY	72	6,309	14,722	93	477	66.00
69.00	06900	ELECTROCARDIOLOGY	401	4,054	12,753	0	1,226	69.00
69.01	06901	CARDIAC REHAB	205	2,210	21,439	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,710	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,984	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,079	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	239	3,032	19,713	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,596	31,551	66,148	0	1,990	90.00
90.01	09001	WOUND CARE	17	408	10,552	0	0	90.01
91.00	09100	EMERGENCY	1,582	14,521	59,046	4,113	3,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,706	246,763	620,266	16,731	36,311	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	29	0	0	436	194.00
194.01	07951	MOB	0	275	33,371	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	617	6,093	8,806	0	545	194.04
194.05	07955	PHYSICIANS OFFICE	7,491	69,392	55,400	0	3,134	194.05
194.06	07956	THE ARBORS	0	1,396	40,389	0	1,772	194.06
194.07	07957	PAIN MANAGEMENT	347	2,497	0	0	0	194.07
194.08	07958	OPS	0	387	29,814	0	1,090	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	31	658	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,192	327,490	788,046	16,731	43,288	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
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	146,493					10.00
11.00	01100	CAFETERIA	0	76,241				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,616	62,602			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,640	0	112,507		14.00
15.00	01500	PHARMACY	0	2,457	0	0	62,738	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,374	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,142	9,824	22,394	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,648	2,510	5,722	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
43.00	04300	NURSERY	0	1,048	2,389	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,917	13,487	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,389	5,445	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,720	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,957	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	494	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,781	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	785	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	112,507	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	62,738	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	732	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	20,238	0	0	0	90.00
90.01	09001	WOUND CARE	0	59	0	0	0	90.01
91.00	09100	EMERGENCY	0	5,776	13,165	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,790	66,317	62,602	112,507	62,738	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	2,312	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	7,612	0	0	0	194.05
194.06	07956	THE ARBORS	52,703	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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)	146,493	76,241	62,602	112,507	62,738	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
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	194,119					16.00
17.00	01700	SOCIAL SERVICE	0	40,289				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,678	30,352	941,434	0	941,434	30.00
31.00	03100	INTENSIVE CARE UNIT	1,626	3,614	164,099	0	164,099	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
43.00	04300	NURSERY	1,817	2,065	33,877	0	33,877	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,550	0	570,882	0	570,882	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,143	0	142,914	0	142,914	52.00
53.00	05300	ANESTHESIOLOGY	2,430	0	47,119	0	47,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,511	0	283,416	0	283,416	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	23,881	0	183,732	0	183,732	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,219	0	1,906	0	1,906	63.00
65.00	06500	RESPIRATORY THERAPY	7,750	0	27,613	0	27,613	65.00
66.00	06600	PHYSICAL THERAPY	4,430	0	107,240	0	107,240	66.00
69.00	06900	ELECTROCARDIOLOGY	4,756	0	49,332	0	49,332	69.00
69.01	06901	CARDIAC REHAB	770	0	142,848	0	142,848	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	117,217	0	117,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	5,984	0	5,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	77,817	0	77,817	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	12,846	0	74,099	0	74,099	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,958	0	236,274	0	236,274	90.00
90.01	09001	WOUND CARE	417	0	25,238	0	25,238	90.01
91.00	09100	EMERGENCY	17,186	4,258	447,037	0	447,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	167,968	40,289	3,680,078	0	3,680,078	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	465	0	465	194.00
194.01	07951	MOB	0	0	77,243	0	77,243	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	66,611	0	66,611	194.04
194.05	07955	PHYSICIANS OFFICE	25,891	0	331,886	0	331,886	194.05
194.06	07956	THE ARBORS	0	0	317,501	0	317,501	194.06
194.07	07957	PAIN MANAGEMENT	260	0	3,104	0	3,104	194.07
194.08	07958	OPS	0	0	92,578	0	92,578	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	689	0	689	194.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	194,119	40,289	4,570,155	0	4,570,155	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	198,774					1.00
1.01	00101	MOB	0	44,997				1.01
1.02	00102	OPS	0	0	18,596			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,667	0	0	31,266,802		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,340	4,107	0	3,625,878	-7,779,915	5.00
7.00	00700	OPERATION OF PLANT	35,311	266	2,196	596,348	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	624	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,397	142	81	508,805	0	9.00
10.00	01000	DIETARY	5,731	0	0	182,595	0	10.00
11.00	01100	CAFETERIA	2,858	0	0	423,717	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,217	0	0	558,470	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	220,480	0	14.00
15.00	01500	PHARMACY	2,103	0	0	430,855	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	613,353	0	16.00
17.00	01700	SOCIAL SERVICE	1,424	0	0	336,963	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,542	0	0	2,556,003	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,283	0	0	592,332	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
43.00	04300	NURSERY	902	0	0	273,097	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,487	0	0	1,430,028	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,949	0	0	622,543	0	52.00
53.00	05300	ANESTHESIOLOGY	1,763	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,111,214	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,837	1,345	727	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	344	0	0	654,294	0	65.00
66.00	06600	PHYSICAL THERAPY	3,820	0	0	64,064	0	66.00
69.00	06900	ELECTROCARDIOLOGY	479	2,830	0	356,440	0	69.00
69.01	06901	CARDIAC REHAB	5,563	0	0	182,289	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	733	4,382	0	211,910	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	210	16,954	0	6,758,806	0	90.00
90.01	09001	WOUND CARE	0	2,738	0	14,737	0	90.01
91.00	09100	EMERGENCY	15,321	0	0	1,404,725	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,505	32,764	4,563	23,729,946	-7,779,915	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	8,659	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	2,285	0	0	547,943	0	194.04
194.05	07955	PHYSICIANS OFFICE	4,504	3,574	6,297	6,652,969	0	194.05
194.06	07956	THE ARBORS	10,480	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	308,023	0	194.07
194.08	07958	OPS	0	0	7,736	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	27,921	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,196,276	226,553	147,326	8,839,259		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.110789	5.034847	7.922456	0.282704		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				35,192		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001126		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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,880,163					5.00
7.00	00700	OPERATION OF PLANT	3,674,595	204,480				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	182,689	624	283,392			8.00
9.00	00900	HOUSEKEEPING	890,880	1,620	0	6,353		9.00
10.00	01000	DIETARY	509,239	5,731	0	0	7,744	10.00
11.00	01100	CAFETERIA	699,437	2,858	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	772,128	2,217	0	20	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	891,664	4,127	0	288	0	14.00
15.00	01500	PHARMACY	1,107,145	2,103	0	45	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,172,749	7,445	0	24	0	16.00
17.00	01700	SOCIAL SERVICE	473,124	1,424	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,467,989	29,542	73,570	2,117	4,448	30.00
31.00	03100	INTENSIVE CARE UNIT	913,337	5,283	8,109	320	510	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
43.00	04300	NURSERY	404,743	902	18,422	13	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,819,815	19,487	92,599	670	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	983,707	4,949	0	70	0	52.00
53.00	05300	ANESTHESIOLOGY	107,209	1,763	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,196,801	10,587	19,440	320	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,792,227	6,909	0	140	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	108,859	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,006,771	344	0	180	0	65.00
66.00	06600	PHYSICAL THERAPY	999,568	3,820	1,577	70	0	66.00
69.00	06900	ELECTROCARDIOLOGY	642,261	3,309	0	180	0	69.00
69.01	06901	CARDIAC REHAB	350,060	5,563	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,170	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	948,033	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,388,894	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	480,357	5,115	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,998,529	17,164	0	292	0	90.00
90.01	09001	WOUND CARE	64,700	2,738	0	0	0	90.01
91.00	09100	EMERGENCY	2,300,470	15,321	69,675	580	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,094,150	160,945	283,392	5,329	4,958	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	4,620	0	0	64	0	194.00
194.01	07951	MOB	43,600	8,659	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	965,253	2,285	0	80	0	194.04
194.05	07955	PHYSICIANS OFFICE	10,990,207	14,375	0	460	0	194.05
194.06	07956	THE ARBORS	221,241	10,480	0	260	2,786	194.06
194.07	07957	PAIN MANAGEMENT	395,563	0	0	0	0	194.07
194.08	07958	OPS	61,287	7,736	0	160	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	104,242	0	0	0	0	194.09
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)	7,779,915	4,225,634	222,980	1,057,953	704,037	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.149959	20.665268	0.786825	166.528097	90.913869	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	327,490	788,046	16,731	43,288	146,493	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006312	3.853903	0.059038	6.813789	18.916968	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			5.00	7.00	8.00	9.00	10.00	
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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
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	651,544					11.00
13.00	01300	NURSING ADMINISTRATION	13,808	234,696				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,013	0	100			14.00
15.00	01500	PHARMACY	20,996	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	149,432,833	16.00
17.00	01700	SOCIAL SERVICE	11,741	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,956	83,956	0	0	10,529,654	30.00
31.00	03100	INTENSIVE CARE UNIT	21,452	21,452	0	0	1,251,772	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
43.00	04300	NURSERY	8,955	8,955	0	0	1,398,961	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,563	50,563	0	0	27,364,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,414	20,414	0	0	3,189,030	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,870,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,336	0	0	0	12,710,178	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	18,384,177	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	938,576	63.00
65.00	06500	RESPIRATORY THERAPY	25,273	0	0	0	5,966,152	65.00
66.00	06600	PHYSICAL THERAPY	4,222	0	0	0	3,409,982	66.00
69.00	06900	ELECTROCARDIOLOGY	15,219	0	0	0	3,661,102	69.00
69.01	06901	CARDIAC REHAB	6,712	0	0	0	592,644	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	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	100	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	6,254	0	0	0	9,888,913	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	172,951	0	0	0	14,594,275	90.00
90.01	09001	WOUND CARE	508	0	0	0	320,689	90.01
91.00	09100	EMERGENCY	49,357	49,356	0	0	13,230,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	566,730	234,696	100	100	129,301,467	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	19,759	0	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	65,055	0	0	0	19,931,448	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	199,918	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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)	863,385	955,359	1,177,192	1,351,947	1,506,463	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.325137	4.070623	11,771.920000	13,519.470000	0.010081	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,241	62,602	112,507	62,738	194,119	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.117016	0.266737	1,125.070000	627.380000	0.001299	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB			1.01
1.02	00102	OPS			1.02
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
17.00	01700	SOCIAL SERVICE	22,238		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	16,753		30.00
31.00	03100	INTENSIVE CARE UNIT	1,995		31.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
43.00	04300	NURSERY	1,140		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
69.01	06901	CARDIAC REHAB	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	WOUND CARE	0		90.01
91.00	09100	EMERGENCY	2,350		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,238		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	FOUNDATION	0		194.00
194.01	07951	MOB	0		194.01
194.02	07952	NONREIMBURSABLE OTHER	0		194.02
194.03	07953	PIH	0		194.03
194.04	07954	HEALTH COMPANIES	0		194.04
194.05	07955	PHYSICIANS OFFICE	0		194.05
194.06	07956	THE ARBORS	0		194.06
194.07	07957	PAIN MANAGEMENT	0		194.07
194.08	07958	OPS	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0		194.09
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)	589,058		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.488803		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,289		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.811719		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 12:00 pm

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 12:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,416,271		6,416,271	0	6,416,271	30.00
31.00	03100	INTENSIVE CARE UNIT	1,446,724		1,446,724	0	1,446,724	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	593,357		593,357	0	593,357	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,378,528		4,378,528	0	4,378,528	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,387,450		1,387,450	0	1,387,450	52.00
53.00	05300	ANESTHESIOLOGY	178,576		178,576	0	178,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,995,181		2,995,181	0	2,995,181	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,562,368		3,562,368	0	3,562,368	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	134,645		134,645	0	134,645	63.00
65.00	06500	RESPIRATORY THERAPY	1,288,464	0	1,288,464	0	1,288,464	65.00
66.00	06600	PHYSICAL THERAPY	1,281,272	0	1,281,272	0	1,281,272	66.00
69.00	06900	ELECTROCARDIOLOGY	894,005		894,005	0	894,005	69.00
69.01	06901	CARDIAC REHAB	532,384		532,384	0	532,384	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,035,257		2,035,257	0	2,035,257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,090,199		1,090,199	0	1,090,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,099,077		4,099,077	0	4,099,077	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	766,071		766,071	0	766,071	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,527,738		6,527,738	21,894	6,549,632	90.00
90.01	09001	WOUND CARE	134,890		134,890	0	134,890	90.01
91.00	09100	EMERGENCY	3,575,405		3,575,405	0	3,575,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,379,899		1,379,899		1,379,899	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	44,697,761	0	44,697,761	21,894	44,719,655	200.00
201.00		Less Observation Beds	1,379,899		1,379,899		1,379,899	201.00
202.00		Total (see instructions)	43,317,862	0	43,317,862	21,894	43,339,756	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 12:00 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	7,309,512		7,309,512			30.00
31.00	03100	INTENSIVE CARE UNIT	996,137		996,137			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,398,453		1,398,453			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,872,443	23,492,117	27,364,560	0.160007	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,279,453	376,595	2,656,048	0.522374	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	236,030	1,634,520	1,870,550	0.095467	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	865,592	11,844,586	12,710,178	0.235652	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,842,628	15,541,549	18,384,177	0.193774	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	477,822	672,368	1,150,190	0.117063	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,464,631	2,413,821	4,878,452	0.264113	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	277,773	3,132,209	3,409,982	0.375742	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	711,562	4,037,240	4,748,802	0.188259	0.000000	69.00
69.01	06901	CARDIAC REHAB	191	592,453	592,644	0.898320	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,538	4,168,487	5,363,025	0.379498	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,232,193	3,811,345	5,043,538	0.216158	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,333,155	5,687,507	9,020,662	0.454410	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	927,992	8,960,921	9,888,913	0.077468	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,315	7,404,093	7,441,408	0.877218	0.000000	90.00
90.01	09001	WOUND CARE	333	320,356	320,689	0.420626	0.000000	90.01
91.00	09100	EMERGENCY	1,573,429	11,632,799	13,206,228	0.270736	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	213,490	2,717,157	2,930,647	0.470851	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	32,244,672	108,440,123	140,684,795			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,244,672	108,440,123	140,684,795			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 12:00 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.160007	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.522374	52.00
53.00	05300	ANESTHESIOLOGY	0.095467	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235652	54.00
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	0.193774	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117063	63.00
65.00	06500	RESPIRATORY THERAPY	0.264113	65.00
66.00	06600	PHYSICAL THERAPY	0.375742	66.00
69.00	06900	ELECTROCARDIOLOGY	0.188259	69.00
69.01	06901	CARDIAC REHAB	0.898320	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454410	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.077468	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.880160	90.00
90.01	09001	WOUND CARE	0.420626	90.01
91.00	09100	EMERGENCY	0.270736	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.470851	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 12:00 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	6,416,271		6,416,271	0	6,416,271	30.00
31.00	03100	INTENSIVE CARE UNIT	1,446,724		1,446,724	0	1,446,724	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	593,357		593,357	0	593,357	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,378,528		4,378,528	0	4,378,528	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,387,450		1,387,450	0	1,387,450	52.00
53.00	05300	ANESTHESIOLOGY	178,576		178,576	0	178,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,995,181		2,995,181	0	2,995,181	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,562,368		3,562,368	0	3,562,368	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	134,645		134,645	0	134,645	63.00
65.00	06500	RESPIRATORY THERAPY	1,288,464	0	1,288,464	0	1,288,464	65.00
66.00	06600	PHYSICAL THERAPY	1,281,272	0	1,281,272	0	1,281,272	66.00
69.00	06900	ELECTROCARDIOLOGY	894,005		894,005	0	894,005	69.00
69.01	06901	CARDIAC REHAB	532,384		532,384	0	532,384	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,035,257		2,035,257	0	2,035,257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,090,199		1,090,199	0	1,090,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,099,077		4,099,077	0	4,099,077	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	766,071		766,071	0	766,071	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,527,738		6,527,738	21,894	6,549,632	90.00
90.01	09001	WOUND CARE	134,890		134,890	0	134,890	90.01
91.00	09100	EMERGENCY	3,575,405		3,575,405	0	3,575,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,379,899		1,379,899		1,379,899	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	44,697,761	0	44,697,761	21,894	44,719,655	200.00
201.00		Less Observation Beds	1,379,899		1,379,899		1,379,899	201.00
202.00		Total (see instructions)	43,317,862	0	43,317,862	21,894	43,339,756	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 12:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,309,512		7,309,512			30.00
31.00	03100	INTENSIVE CARE UNIT	996,137		996,137			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,398,453		1,398,453			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,872,443	23,492,117	27,364,560	0.160007	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,279,453	376,595	2,656,048	0.522374	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	236,030	1,634,520	1,870,550	0.095467	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	865,592	11,844,586	12,710,178	0.235652	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,842,628	15,541,549	18,384,177	0.193774	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	477,822	672,368	1,150,190	0.117063	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,464,631	2,413,821	4,878,452	0.264113	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	277,773	3,132,209	3,409,982	0.375742	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	711,562	4,037,240	4,748,802	0.188259	0.000000	69.00
69.01	06901	CARDIAC REHAB	191	592,453	592,644	0.898320	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,538	4,168,487	5,363,025	0.379498	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,232,193	3,811,345	5,043,538	0.216158	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,333,155	5,687,507	9,020,662	0.454410	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	927,992	8,960,921	9,888,913	0.077468	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,315	7,404,093	7,441,408	0.877218	0.000000	90.00
90.01	09001	WOUND CARE	333	320,356	320,689	0.420626	0.000000	90.01
91.00	09100	EMERGENCY	1,573,429	11,632,799	13,206,228	0.270736	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	213,490	2,717,157	2,930,647	0.470851	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	32,244,672	108,440,123	140,684,795			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,244,672	108,440,123	140,684,795			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 12:00 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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/30/2018 12:00 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	941,434	0	941,434	5,431	173.34	30.00
31.00	INTENSIVE CARE UNIT	164,099		164,099	510	321.76	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
43.00	NURSERY	33,877		33,877	1,113	30.44	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,139,410		1,139,410	7,054		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,875	325,013	30.00
31.00	INTENSIVE CARE UNIT	264	84,945	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	2,139	409,958	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/30/2018 12:00 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	570,882	27,364,560	0.020862	1,214,331	25,333	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,914	2,656,048	0.053807	319	17	52.00
53.00	05300	ANESTHESIOLOGY	47,119	1,870,550	0.025190	69,380	1,748	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,416	12,710,178	0.022298	523,777	11,679	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	183,732	18,384,177	0.009994	1,468,252	14,674	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,906	1,150,190	0.001657	205,367	340	63.00
65.00	06500	RESPIRATORY THERAPY	27,613	4,878,452	0.005660	1,498,962	8,484	65.00
66.00	06600	PHYSICAL THERAPY	107,240	3,409,982	0.031449	184,452	5,801	66.00
69.00	06900	ELECTROCARDIOLOGY	49,332	4,748,802	0.010388	448,511	4,659	69.00
69.01	06901	CARDIAC REHAB	142,848	592,644	0.241035	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,217	5,363,025	0.021857	454,732	9,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,984	5,043,538	0.001186	808,242	959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,817	9,020,662	0.008627	1,728,672	14,913	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	74,099	9,888,913	0.007493	464,589	3,481	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	236,274	7,441,408	0.031751	27,836	884	90.00
90.01	09001	WOUND CARE	25,238	320,689	0.078699	0	0	90.01
91.00	09100	EMERGENCY	447,037	13,206,228	0.033850	928,058	31,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,467	2,930,647	0.069086	51,264	3,542	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,743,135	130,980,693		10,076,744	137,868	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/30/2018 12:00 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
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	5,431	0.00	1,875	30.00
31.00	03100	INTENSIVE CARE UNIT		0	510	0.00	264	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
43.00	04300	NURSERY		0	1,113	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	7,054		2,139	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
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 12:00 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
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 12:00 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	27,364,560	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,656,048	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,870,550	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,710,178	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	18,384,177	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,150,190	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,878,452	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,409,982	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,748,802	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	592,644	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,363,025	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,043,538	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,020,662	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	9,888,913	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	7,441,408	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	320,689	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	13,206,228	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,930,647	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	130,980,693		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 12:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,214,331	0	5,074,633	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	319	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	69,380	0	334,740	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	523,777	0	3,076,889	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,468,252	0	1,943,284	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	205,367	0	201,904	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,498,962	0	980,635	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	184,452	0	19,276	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	448,511	0	1,507,509	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	253,125	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	454,732	0	747,664	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	808,242	0	1,110,446	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,728,672	0	2,116,060	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	464,589	0	3,258,717	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	27,836	0	1,533,659	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	3,406	0	90.01
91.00	09100	EMERGENCY	0.000000	928,058	0	2,392,641	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	51,264	0	728,988	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		10,076,744	0	25,283,576	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 12:00 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	0.160007	5,074,633	0	0	811,977	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.522374	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.095467	334,740	0	0	31,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235652	3,076,889	0	594	725,075	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.193774	1,943,284	0	0	376,558	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117063	201,904	0	0	23,635	63.00
65.00	06500	RESPIRATORY THERAPY	0.264113	980,635	0	527	258,998	65.00
66.00	06600	PHYSICAL THERAPY	0.375742	19,276	0	0	7,243	66.00
69.00	06900	ELECTROCARDIOLOGY	0.188259	1,507,509	0	0	283,802	69.00
69.01	06901	CARDIAC REHAB	0.898320	253,125	0	0	227,387	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379498	747,664	0	0	283,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216158	1,110,446	0	0	240,032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454410	2,116,060	0	50,323	961,559	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.077468	3,258,717	0	24,647	252,446	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.877218	1,533,659	91	2,315	1,345,353	90.00
90.01	09001	WOUND CARE	0.420626	3,406	0	0	1,433	90.01
91.00	09100	EMERGENCY	0.270736	2,392,641	0	0	647,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.470851	728,988	0	0	343,245	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		25,283,576	91	78,406	6,822,211	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,283,576	91	78,406	6,822,211	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 12:00 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	140		54.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	139		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,867		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	1,909		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	80	2,031		90.00
90.01	09001	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	80	27,086		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	80	27,086		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 12:00 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)	5,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,431	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)	4,263	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,875	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)	6,416,271	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)	6,416,271	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)	6,416,271	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)	1,181.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,215,163	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,215,163	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 12:00 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,446,724	510	2,836.71	264	748,891	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)	2,651,400	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,615,454	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)	409,958	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	137,868	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	547,826	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,067,628	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,168	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,181.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,379,899	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 12:00 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	941,434	6,416,271	0.146726	1,379,899	202,467	90.00
91.00	Nursing School cost	0	6,416,271	0.000000	1,379,899	0	91.00
92.00	Allied health cost	0	6,416,271	0.000000	1,379,899	0	92.00
93.00	All other Medical Education	0	6,416,271	0.000000	1,379,899	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 12:00 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)	5,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,431	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)	4,263	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)	213	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)	1,113	15.00
16.00	Nursery days (title V or XIX only)	107	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)	6,416,271	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)	6,416,271	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)	6,416,271	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)	1,181.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	251,642	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)	251,642	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 12:00 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)	593,357	1,113	533.12	107	57,044	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,446,724	510	2,836.71	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)	310,471	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	619,157	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,168	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,181.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,379,899	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 12:00 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	941,434	6,416,271	0.146726	1,379,899	202,467	90.00
91.00	Nursing School cost	0	6,416,271	0.000000	1,379,899	0	91.00
92.00	Allied health cost	0	6,416,271	0.000000	1,379,899	0	92.00
93.00	All other Medical Education	0	6,416,271	0.000000	1,379,899	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 12:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,221,302		30.00
31.00	03100	INTENSIVE CARE UNIT		508,277		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160007	1,214,331	194,301	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.522374	319	167	52.00
53.00	05300	ANESTHESIOLOGY	0.095467	69,380	6,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235652	523,777	123,429	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.193774	1,468,252	284,509	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117063	205,367	24,041	63.00
65.00	06500	RESPIRATORY THERAPY	0.264113	1,498,962	395,895	65.00
66.00	06600	PHYSICAL THERAPY	0.375742	184,452	69,306	66.00
69.00	06900	ELECTROCARDIOLOGY	0.188259	448,511	84,436	69.00
69.01	06901	CARDIAC REHAB	0.898320	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379498	454,732	172,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216158	808,242	174,708	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454410	1,728,672	785,526	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.077468	464,589	35,991	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.880160	27,836	24,500	90.00
90.01	09001	WOUND CARE	0.420626	0	0	90.01
91.00	09100	EMERGENCY	0.270736	928,058	251,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.470851	51,264	24,138	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,076,744	2,651,400	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)		10,076,744		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 12:00 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		301,135		30.00
31.00	03100	INTENSIVE CARE UNIT		30,753		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		168,502		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160007	224,214	35,876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.522374	229,979	120,135	52.00
53.00	05300	ANESTHESIOLOGY	0.095467	14,515	1,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235652	27,884	6,571	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.193774	112,626	21,824	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117063	18,285	2,140	63.00
65.00	06500	RESPIRATORY THERAPY	0.264113	68,161	18,002	65.00
66.00	06600	PHYSICAL THERAPY	0.375742	4,642	1,744	66.00
69.00	06900	ELECTROCARDIOLOGY	0.188259	8,998	1,694	69.00
69.01	06901	CARDIAC REHAB	0.898320	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379498	66,840	25,366	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216158	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454410	133,221	60,537	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.077468	24,857	1,926	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.877218	0	0	90.00
90.01	09001	WOUND CARE	0.420626	0	0	90.01
91.00	09100	EMERGENCY	0.270736	42,680	11,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.470851	3,642	1,715	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		980,544	310,471	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)		980,544		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 12:00 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160007	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.522374	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.095467	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235652	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.193774	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117063	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.264113	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.375742	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.188259	0	0	69.00
69.01	06901	CARDIAC REHAB	0.898320	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379498	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216158	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454410	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.077468	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.877218	0	0	90.00
90.01	09001	WOUND CARE	0.420626	0	0	90.01
91.00	09100	EMERGENCY	0.270736	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.470851	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 12:00 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)	3,262,442	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,141,874	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)	5,090	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)	79.80	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)	4.39	30.00
31.00	Percentage of Medicaid patient days (see instructions)	29.09	31.00
32.00	Sum of lines 30 and 31	33.48	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	132,129	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 12:00 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	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000050036	0.000070470	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	299,089	476,849	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	223,702	120,192	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	343,894		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)	4,885,429		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,982,978		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,982,978	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	351,887	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)	7,334,865	59.00
60.00	Primary payer payments	22,962	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,311,903	61.00
62.00	Deductibles billed to program beneficiaries	694,783	62.00
63.00	Coinsurance billed to program beneficiaries	4,606	63.00
64.00	Allowable bad debts (see instructions)	72,570	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	47,171	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,494	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,659,685	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)	-38,427	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/30/2018 12:00 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	716,739	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	275,832	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)		7,613,829	71.00
71.01	Sequestration adjustment (see instructions)		152,277	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		7,421,798	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)		39,754	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		259,536	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2018 12:00 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	3,262,442	0	3,262,442		3,262,442	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,141,874	0		1,141,874	1,141,874	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	5,090	0	0	5,090	5,090	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	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	132,129	0	97,873	34,256	132,129	11.00
11.01	Uncompensated care payments	36.00	343,894	0	223,702	120,192	343,894	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	4,885,429	0	3,584,017	1,301,412	4,885,429	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,982,978	0	5,193,736	1,789,242	6,982,978	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,982,978	0	5,193,736	1,789,242	6,982,978	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	351,887	0	259,694	92,193	351,887	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2018 12:00 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	5,453,430	1,881,435	7,334,865	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	351,033	0	259,694	91,339	351,033	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	854	0	0	854	854	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	351,887	0	259,694	92,193	351,887	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				0.131429	0.146607		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			716,739		716,739	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				275,832	275,832	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2018 12:00 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	3,262,442	3,262,442		3,262,442	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,141,874		1,141,874	1,141,874	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	5,090	0	5,090	5,090	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	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	132,129	97,873	34,256	132,129	11.00
11.01	Uncompensated care payments	36.00	343,894	223,702	120,192	343,894	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	4,885,429	3,584,017	1,301,412	4,885,429	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,982,978	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,982,978	6,982,978	0	6,982,978	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	351,887	259,694	92,193	351,887	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			7,242,672	92,193	7,334,865	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2018 12:00 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	351,033	259,694	91,339	351,033	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	854	0	854	854	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	351,887	259,694	92,193	351,887	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	716,739	716,739		716,739	28.00
29.00	Low volume adjustment on or after October 1	70.97	275,832		275,832	275,832	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-38,427	-38,861	434	-38,427	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 12:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	27,166	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,822,211	2.00
3.00	OPPS payments	6,678,053	3.00
4.00	Outlier payment (see instructions)	182,264	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)	27,166	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	78,497	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)	78,497	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)	78,497	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	51,331	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)	27,166	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)	6,860,317	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,466,490	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)	5,420,993	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)	5,420,993	30.00
31.00	Primary payer payments	2,670	31.00
32.00	Subtotal (line 30 minus line 31)	5,418,323	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)	176,285	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	114,585	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	171,629	36.00
37.00	Subtotal (see instructions)	5,532,908	37.00
38.00	MSP-LCC reconciliation amount from PS&R	92	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)	5,532,816	40.00
40.01	Sequestration adjustment (see instructions)	110,656	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,306,210	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	115,950	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2018 12:00 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		7,145,966		5,306,210	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	275,832		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		275,832		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,421,798		5,306,210	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		39,754		115,950	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,461,552		5,422,160	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2018 12:00 pm

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/30/2018 12:00 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 - SWING BEDS

Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/30/2018 12:00 pm

Title XVIII | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0072 Component CCN: 15-U072	Period: From 01/01/2017 To 12/31/2017	Worksheet E-2 Date/Time Prepared: 5/30/2018 12:00 pm
	Title XIX	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 12:00 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	619,157		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)	619,157	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)	619,157	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	500,391		8.00
9.00	Ancillary service charges	980,544	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)	1,480,935	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)	1,480,935	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	861,778	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)	619,157	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)	619,157	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)	619,157	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)	619,157	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	619,157	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)	619,157	0	40.00
41.00	Interim payments	738,673	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-119,516	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: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/30/2018 12:00 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	26,021,136	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	33,014,361	0	0	0	4.00
5.00	Other receivable	1,783,341	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,072,214	0	0	0	6.00
7.00	Inventory	1,437,625	0	0	0	7.00
8.00	Prepaid expenses	348,348	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	27,139	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,559,736	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	692,370	0	0	0	13.00
14.00	Accumulated depreciation	-363,651	0	0	0	14.00
15.00	Buildings	60,823,505	0	0	0	15.00
16.00	Accumulated depreciation	-36,432,695	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,165,513	0	0	0	19.00
20.00	Accumulated depreciation	-3,105,082	0	0	0	20.00
21.00	Automobiles and trucks	123,002	0	0	0	21.00
22.00	Accumulated depreciation	-96,262	0	0	0	22.00
23.00	Major movable equipment	41,254,763	0	0	0	23.00
24.00	Accumulated depreciation	-27,934,978	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)	42,332,268	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	12,390,050	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,390,050	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	95,282,054	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,226,615	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,206,127	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,972,936	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	-4,994,667	0	0	0	43.00
44.00	Other current liabilities	532,741	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,943,752	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	18,072,950	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,072,950	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,016,702	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	69,265,352				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)	69,265,352	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	95,282,054	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/30/2018 12:00 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		67,117,571		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,147,781				2.00
3.00	Total (sum of line 1 and line 2)		69,265,352		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		69,265,352		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)		69,265,352		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2018 12:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,707,965		8,707,965	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	0		0	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)	8,707,965		8,707,965	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	996,137		996,137	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)	996,137		996,137	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,704,102		9,704,102	17.00
18.00	Ancillary services	20,716,003	86,365,718	107,081,721	18.00
19.00	Outpatient services	1,824,567	22,074,405	23,898,972	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	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	PHYSICIAN CLINICS	0	21,567,378	21,567,378	27.00
27.01	PHYSICIAN PROFESSIONAL FEES	891,030	7,152,867	8,043,897	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	33,135,702	137,160,368	170,296,070	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,671,998		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)		70,671,998		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/30/2018 12:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	170,296,070	1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,933,899	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,362,171	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,671,998	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-309,827	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	2,175,883	24.00
24.01	INVESTMENT INCOME	139,907	24.01
24.02	LOSS ON SALE OF EQUIPMENT	-15,875	24.02
24.03	OTHER NON-OPERATING REVENUE	157,693	24.03
25.00	Total other income (sum of lines 6-24)	2,457,608	25.00
26.00	Total (line 5 plus line 25)	2,147,781	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)	2,147,781	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0072	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/30/2018 12:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	351,033	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	854	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)	13.58	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)	351,887	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