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: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/28/2018 4:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/28/2018 Time: 4:24 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 REHABILITATION HOSPITAL OF FT WAYNE (15-3030) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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	54,212	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	54,212	0	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 4:23 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46804-	County: ALLEN	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	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060	5	11/01/1993	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	237	0	0	0	819		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:23 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:23 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).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 4:23 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.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:23 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 4:23 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	44,568	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:23 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

		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)			170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2018 4:23 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/22/2018	Y	02/22/2018	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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2018 4:23 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 4:23 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.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 4:23 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	36	13,140	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)		36	13,140	0.00	0	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)		36	13,140	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		36				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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2018 4:23 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,601	237	6,461			1.00
2.00	HMO and other (see instructions)	823	819				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)	2,601	237	6,461			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)	2,601	237	6,461	0.00	95.44	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	95.44	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 4:23 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	232	82	563	1.00
2.00	HMO and other (see instructions)			66	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	232	82	563	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		282,710	282,710	161,693	444,403	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		117,709	117,709	102,497	220,206	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132,682	28,977	161,659	837,487	999,146	4.00
5.01	00570	ADMITTING	63,346	86,949	150,295	-173	150,122	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	235,360	1,867,999	2,103,359	-1,373,875	729,484	5.02
7.00	00700	OPERATION OF PLANT	213,415	488,738	702,153	0	702,153	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,941	36,941	0	36,941	8.00
9.00	00900	HOUSEKEEPING	106,190	28,157	134,347	-52	134,295	9.00
10.00	01000	DIETARY	348,860	209,387	558,247	-99,417	458,830	10.00
11.00	01100	CAFETERIA	0	0	0	98,136	98,136	11.00
13.00	01300	NURSING ADMINISTRATION	618,700	78,867	697,567	-194	697,373	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,556	115,107	128,663	-81,188	47,475	14.00
15.00	01500	PHARMACY	88,528	276,764	365,292	-258,276	107,016	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,884	63,059	229,943	-2,701	227,242	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,190,665	372,856	2,563,521	342,662	2,906,183	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,478	7,478	0	7,478	54.00
60.00	06000	LABORATORY	21,040	25,049	46,089	0	46,089	60.00
65.00	06500	RESPIRATORY THERAPY	10,004	12,963	22,967	-8,377	14,590	65.00
66.00	06600	PHYSICAL THERAPY	552,731	65,615	618,346	-72	618,274	66.00
67.00	06700	OCCUPATIONAL THERAPY	768,196	70,180	838,376	-150	838,226	67.00
68.00	06800	SPEECH PATHOLOGY	319,380	37,472	356,852	0	356,852	68.00
69.00	06900	ELECTROCARDIOLOGY	82	254	336	0	336	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,761	16,761	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	236,084	236,084	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	40,236	3,988	44,224	-24	44,200	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	84,550	84,550	0	84,550	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,889,855	4,361,769	10,251,624	-29,179	10,222,445	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	174	5,711	5,885	-97	5,788	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	29,276	29,276	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	5,890,029	4,367,480	10,257,509	0	10,257,509	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,205	445,608		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-64,037	156,169		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	999,146		4.00
5.01	00570	ADMITTING	-31,313	118,809		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	321,433	1,050,917		5.02
7.00	00700	OPERATION OF PLANT	-5,918	696,235		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,264	81,205		8.00
9.00	00900	HOUSEKEEPING	0	134,295		9.00
10.00	01000	DIETARY	0	458,830		10.00
11.00	01100	CAFETERIA	-81,359	16,777		11.00
13.00	01300	NURSING ADMINISTRATION	0	697,373		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-27,086	20,389		14.00
15.00	01500	PHARMACY	0	107,016		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	227,242		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-342,739	2,563,444		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,478		54.00
60.00	06000	LABORATORY	0	46,089		60.00
65.00	06500	RESPIRATORY THERAPY	0	14,590		65.00
66.00	06600	PHYSICAL THERAPY	0	618,274		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	838,226		67.00
68.00	06800	SPEECH PATHOLOGY	0	356,852		68.00
69.00	06900	ELECTROCARDIOLOGY	0	336		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,761		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	236,084		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	44,200		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	84,550		76.01
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-185,550	10,036,895		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,788		192.00
194.00	07950	NON-REIMBURSABLE COST	0	0		194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	29,276		194.01
194.02	07952	TENANT LEASED SPACE	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-185,550	10,071,959		200.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 4:23 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	837,646	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	837,646	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	405	1.00
	TOTALS		0	405	
	C - RENTAL AND LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	102,497	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	102,497	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,114	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	151,579	2.00
	TOTALS		0	161,693	
	E - MARKETING				
1.00	MARKETING/PUBLIC RELATIONS	194.01	16,396	12,880	1.00
	TOTALS		16,396	12,880	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16,356	1.00
	TOTALS		0	16,356	
	G - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	236,084	1.00
	TOTALS		0	236,084	
	H - PHYSICIAN DIRECOTRS				
1.00	ADULTS & PEDIATRICS	30.00	0	342,739	1.00
	TOTALS		0	342,739	
	I - DIETARY				
1.00	CAFETERIA	11.00	59,224	38,912	1.00
	TOTALS		59,224	38,912	
500.00	Grand Total: Increases		75,620	1,749,212	500.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 4:23 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	837,351	0		1.00
2.00	HOUSEKEEPING	9.00	0	52	0		2.00
3.00	DIETARY	10.00	0	57	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	9	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	24	0		5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	150	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3	0		7.00
	TOTALS		0	837,646			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	405	0		1.00
	TOTALS		0	405			
	C - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	159	10		1.00
2.00	ADMITTING	5.01	0	173	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	2,816	0		3.00
4.00	DIETARY	10.00	0	1,224	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	185	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	64,832	0		6.00
7.00	PHARMACY	15.00	0	22,192	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,677	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	77	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	7,972	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	72	0		11.00
12.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	24	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	94	0		13.00
	TOTALS		0	102,497			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	161,693	12		1.00
2.00		0.00	0	0	13		2.00
	TOTALS		0	161,693			
	E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	16,396	12,880	0		1.00
	TOTALS		16,396	12,880			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,356	0		1.00
	TOTALS		0	16,356			
	G - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	236,084	0		1.00
	TOTALS		0	236,084			
	H - PHYSICIAN DIRECOTRS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	342,739	0		1.00
	TOTALS		0	342,739			
	I - DIETARY						
1.00	DIETARY	10.00	59,224	38,912	0		1.00
	TOTALS		59,224	38,912			
500.00	Grand Total: Decreases		75,620	1,749,212			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2018 4:23 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	900,000	0	0	0	0	1.00
2.00	Land Improvements	276,453	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,859,432	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	745,332	224,406	0	224,406	0	6.00
7.00	HIT designated Assets	7,715	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,788,932	224,406	0	224,406	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,788,932	224,406	0	224,406	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	900,000	0	1.00
2.00	Land Improvements	276,453	0	2.00
3.00	Buildings and Fixtures	11,859,432	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	969,738	0	6.00
7.00	HIT designated Assets	7,715	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,013,338	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,013,338	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2018 4:23 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	282,710	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	117,709	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	400,419	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	282,710		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	117,709		2.00
3.00	Total (sum of lines 1-2)	0	400,419		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2018 4:23 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,135,885	0	12,135,885	0.941574	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	753,047	0	753,047	0.058426	0	2.00
3.00	Total (sum of lines 1-2)	12,888,932	0	12,888,932	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	233,220	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	53,672	102,497	2.00
3.00	Total (sum of lines 1-2)	0	0	0	286,892	102,497	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	50,695	10,114	151,579	0	445,608	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	156,169	2.00
3.00	Total (sum of lines 1-2)	50,695	10,114	151,579	0	601,777	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 4:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,886	CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00	Television and radio service (chapter 21)	A	-2,620	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-342,739			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	466,255			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-81,359	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-6,309	CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	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	B	-1,559	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-48,751	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-91,558	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 4:23 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	
33.00	MISCELANEOUS INCOME	B	-2,047	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.01	LEGAL FEES	A	-2,010	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	MARKETING	A	-547	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.02
33.03	PATIENT TELEPHONE EXPENSE	A	-61,751	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.06	PATIENT TV CABLE EXPENSE	A	-5,918	OPERATION OF PLANT	7.00	0	33.06
33.07	CHARITABLE CONTRIBUTIONS	A	-89	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.09	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-1,662	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-185,550				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2018 4:23 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - INTEREST	50,695	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	285	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING AND FIXTURES	5,285	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	MOVABLE EQUIPMENT	32,948	0	4.00
4.01	5.02	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE ALLOCATION	156,169	25,158	4.01
4.02	5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS	44,568	90,000	4.02
4.03	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	44,264	0	4.03
4.04	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	79	0	4.04
4.05	5.01	ADMITTING	PASI OPERATING COSTS	4,191	0	4.05
4.06	5.01	ADMITTING	PASI COLLECTION FEES	0	902	4.06
4.07	5.01	ADMITTING	HIIM ALLOCATION	0	25,973	4.07
4.08	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	8,629	4.08
4.09	14.00	CENTRAL SERVICES & SUPPLY	HOSPITAL LAUNDRY SERVICE	0	27,086	4.09
4.10	5.02	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL ALLOCATIONS	305,519	0	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			644,003	177,748	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	LUTHERAN	100.00	7.00
8.00	G	HOSPITAL LAUNDR	100.00	LAUNDRY	100.00	8.00
9.00	B		0.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2018 4:23 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	50,695	11		1.00
2.00	285	9		2.00
3.00	5,285	9		3.00
4.00	32,948	9		4.00
4.01	131,011	0		4.01
4.02	-45,432	0		4.02
4.03	44,264	0		4.03
4.04	79	9		4.04
4.05	4,191	0		4.05
4.06	-902	0		4.06
4.07	-25,973	0		4.07
4.08	-8,629	0		4.08
4.09	-27,086	0		4.09
4.10	305,519	0		4.10
5.00	466,255			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HOSPITAL		7.00
8.00	CONSOL LAUNDRY		8.00
9.00	DEBT COLLECTION		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2018 4:23 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	342,739	342,739	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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			342,739	342,739	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	342,739		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	342,739		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	445,608	445,608				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	156,169		156,169			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	999,146	1,798	776	1,001,720		4.00
5.01	00570	ADMITTING	118,809	9,259	3,996	11,022	143,086	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,050,917	35,070	15,135	38,098	0	5.02
7.00	00700	OPERATION OF PLANT	696,235	81,631	35,227	37,132	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,205	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	134,295	8,819	3,806	18,476	0	9.00
10.00	01000	DIETARY	458,830	0	0	50,394	0	10.00
11.00	01100	CAFETERIA	16,777	34,073	14,704	10,304	0	11.00
13.00	01300	NURSING ADMINISTRATION	697,373	954	412	107,648	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,389	6,735	2,907	2,359	0	14.00
15.00	01500	PHARMACY	107,016	2,854	1,232	15,403	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	227,242	3,272	1,412	29,036	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,120	915	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,563,444	56,736	24,485	381,151	50,206	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,478	3,155	1,362	0	1,105	54.00
60.00	06000	LABORATORY	46,089	0	0	3,661	4,448	60.00
65.00	06500	RESPIRATORY THERAPY	14,590	734	317	1,741	136	65.00
66.00	06600	PHYSICAL THERAPY	618,274	74,037	31,951	96,170	21,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	838,226	34,953	15,084	133,658	22,945	67.00
68.00	06800	SPEECH PATHOLOGY	356,852	2,649	1,143	55,569	12,261	68.00
69.00	06900	ELECTROCARDIOLOGY	336	0	0	14	177	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,761	0	0	0	4,626	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	236,084	0	0	0	21,508	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	44,200	3,023	1,305	7,001	1,746	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	84,550	0	0	0	2,208	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,036,895	361,872	156,169	998,837	143,086	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,788	0	0	30	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	29,276	0	0	2,853	0	194.01
194.02	07952	TENANT LEASED SPACE	0	83,736	0	0	0	194.02
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)	10,071,959	445,608	156,169	1,001,720	143,086	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,139,220	1,139,220				5.02
7.00	00700	OPERATION OF PLANT	850,225	108,432	958,657			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,205	10,356	0	91,561		8.00
9.00	00900	HOUSEKEEPING	165,396	21,093	26,599	0	213,088	9.00
10.00	01000	DIETARY	509,224	64,943	0	0	0	10.00
11.00	01100	CAFETERIA	75,858	9,674	102,765	0	32,227	11.00
13.00	01300	NURSING ADMINISTRATION	806,387	102,841	2,877	0	902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,390	4,131	20,314	0	6,370	14.00
15.00	01500	PHARMACY	126,505	16,134	8,608	0	2,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,962	33,281	9,869	0	3,095	16.00
17.00	01700	SOCIAL SERVICE	3,035	387	6,395	0	2,005	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,076,022	392,295	171,121	51,358	53,662	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,100	1,671	9,515	0	2,984	54.00
60.00	06000	LABORATORY	54,198	6,912	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,518	2,234	2,213	0	694	65.00
66.00	06600	PHYSICAL THERAPY	842,152	107,402	223,300	19,066	70,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,044,866	133,255	105,421	21,137	33,059	67.00
68.00	06800	SPEECH PATHOLOGY	428,474	54,645	7,988	0	2,505	68.00
69.00	06900	ELECTROCARDIOLOGY	527	67	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,387	2,728	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	257,592	32,851	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	57,275	7,304	9,117	0	2,859	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	86,758	11,065	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,950,276	1,123,701	706,102	91,561	213,088	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,818	742	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	32,129	4,098	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	83,736	10,679	252,555	0	0	194.02
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)	10,071,959	1,139,220	958,657	91,561	213,088	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	574,167					10.00
11.00	01100	CAFETERIA	0	220,524				11.00
13.00	01300	NURSING ADMINISTRATION	0	26,915	939,922			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,136	0	64,341		14.00
15.00	01500	PHARMACY	0	2,808	36,016	0	192,770	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,951	0	621	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	574,167	115,233	891,243	52,650	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	2,146	8,560	330	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	473	4,070	792	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,759	0	3,585	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	27,798	0	4,253	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,160	0	745	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	33	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	192,770	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,325	0	87	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	574,167	219,704	939,922	63,063	192,770	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	24	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	820	0	1,254	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
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)	574,167	220,524	939,922	64,341	192,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 4:23 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	315,779					16.00
17.00	01700	SOCIAL SERVICE	0	11,822				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,815	11,822	5,500,388	0	5,500,388	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,438	0	29,708	0	29,708	54.00
60.00	06000	LABORATORY	9,816	0	81,962	0	81,962	60.00
65.00	06500	RESPIRATORY THERAPY	300	0	28,294	0	28,294	65.00
66.00	06600	PHYSICAL THERAPY	47,932	0	1,337,223	0	1,337,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,634	0	1,420,423	0	1,420,423	67.00
68.00	06800	SPEECH PATHOLOGY	27,057	0	531,574	0	531,574	68.00
69.00	06900	ELECTROCARDIOLOGY	390	0	1,017	0	1,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,208	0	34,323	0	34,323	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,463	0	530,676	0	530,676	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,853	0	81,820	0	81,820	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	4,873	0	102,696	0	102,696	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	315,779	11,822	9,680,104	0	9,680,104	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,584	0	6,584	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	38,301	0	38,301	194.01
194.02	07952	TENANT LEASED SPACE	0	0	346,970	0	346,970	194.02
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)	315,779	11,822	10,071,959	0	10,071,959	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,798	776	2,574	2,574	4.00
5.01	00570	ADMITTING	0	9,259	3,996	13,255	28	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	35,070	15,135	50,205	98	5.02
7.00	00700	OPERATION OF PLANT	0	81,631	35,227	116,858	95	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,819	3,806	12,625	47	9.00
10.00	01000	DIETARY	0	0	0	0	129	10.00
11.00	01100	CAFETERIA	0	34,073	14,704	48,777	26	11.00
13.00	01300	NURSING ADMINISTRATION	0	954	412	1,366	277	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,735	2,907	9,642	6	14.00
15.00	01500	PHARMACY	0	2,854	1,232	4,086	40	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,272	1,412	4,684	75	16.00
17.00	01700	SOCIAL SERVICE	0	2,120	915	3,035	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	56,736	24,485	81,221	982	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,155	1,362	4,517	0	54.00
60.00	06000	LABORATORY	0	0	0	0	9	60.00
65.00	06500	RESPIRATORY THERAPY	0	734	317	1,051	4	65.00
66.00	06600	PHYSICAL THERAPY	0	74,037	31,951	105,988	247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	34,953	15,084	50,037	343	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,649	1,143	3,792	143	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,023	1,305	4,328	18	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	361,872	156,169	518,041	2,567	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	7	194.01
194.02	07952	TENANT LEASED SPACE	0	83,736	0	83,736	0	194.02
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	445,608	156,169	601,777	2,574	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	13,283					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	50,303				5.02
7.00	00700	OPERATION OF PLANT	0	4,788	121,741			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	457	0	457		8.00
9.00	00900	HOUSEKEEPING	0	931	3,378	0	16,981	9.00
10.00	01000	DIETARY	0	2,867	0	0	0	10.00
11.00	01100	CAFETERIA	0	427	13,050	0	2,568	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,541	365	0	72	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	182	2,580	0	508	14.00
15.00	01500	PHARMACY	0	712	1,093	0	215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,469	1,253	0	247	16.00
17.00	01700	SOCIAL SERVICE	0	17	812	0	160	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,669	17,323	21,731	256	4,276	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	102	74	1,208	0	238	54.00
60.00	06000	LABORATORY	413	305	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	13	99	281	0	55	65.00
66.00	06600	PHYSICAL THERAPY	2,014	4,742	28,357	95	5,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,128	5,884	13,388	106	2,634	67.00
68.00	06800	SPEECH PATHOLOGY	1,137	2,413	1,014	0	200	68.00
69.00	06900	ELECTROCARDIOLOGY	16	3	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	429	120	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,995	1,451	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	162	323	1,158	0	228	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	205	489	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,283	49,617	89,668	457	16,981	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	181	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	472	32,073	0	0	194.02
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)	13,283	50,303	121,741	457	16,981	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,996					10.00
11.00	01100	CAFETERIA	0	64,848				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,915	14,536			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	334	0	13,252		14.00
15.00	01500	PHARMACY	0	826	557	0	7,529	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,338	0	128	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,996	33,885	13,783	10,844	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	631	132	68	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	139	63	163	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,987	0	738	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,174	0	876	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,988	0	154	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,529	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	390	0	18	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,996	64,607	14,536	12,989	7,529	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	5	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	241	0	258	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
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)	2,996	64,848	14,536	13,252	7,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 4:23 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,194					16.00
17.00	01700	SOCIAL SERVICE	0	4,024				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,574	4,024	199,564	0	199,564	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	79	0	6,218	0	6,218	54.00
60.00	06000	LABORATORY	317	0	1,875	0	1,875	60.00
65.00	06500	RESPIRATORY THERAPY	10	0	1,878	0	1,878	65.00
66.00	06600	PHYSICAL THERAPY	1,548	0	156,296	0	156,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,635	0	85,205	0	85,205	67.00
68.00	06800	SPEECH PATHOLOGY	874	0	12,715	0	12,715	68.00
69.00	06900	ELECTROCARDIOLOGY	13	0	33	0	33	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	330	0	879	0	879	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,533	0	12,508	0	12,508	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	124	0	6,749	0	6,749	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	157	0	851	0	851	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,194	4,024	484,771	0	484,771	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	38	0	38	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	687	0	687	194.01
194.02	07952	TENANT LEASED SPACE	0	0	116,281	0	116,281	194.02
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)	10,194	4,024	601,777	0	601,777	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	728,820					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		591,864				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,940	2,940	5,757,347			4.00
5.01	00570	ADMITTING	15,144	15,144	63,346	31,372,779		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	57,360	57,360	218,964	0	-1,139,220	5.02
7.00	00700	OPERATION OF PLANT	133,512	133,512	213,415	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	14,424	14,424	106,190	0	0	9.00
10.00	01000	DIETARY	0	0	289,636	0	0	10.00
11.00	01100	CAFETERIA	55,728	55,728	59,224	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,560	1,560	618,700	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,016	11,016	13,556	0	0	14.00
15.00	01500	PHARMACY	4,668	4,668	88,528	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,352	5,352	166,884	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,468	3,468	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,796	92,796	2,190,665	11,008,701	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160	5,160	0	242,230	0	54.00
60.00	06000	LABORATORY	0	0	21,040	975,230	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,200	1,200	10,004	29,798	0	65.00
66.00	06600	PHYSICAL THERAPY	121,092	121,092	552,731	4,762,213	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,168	57,168	768,196	5,030,708	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,332	4,332	319,380	2,688,266	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	82	38,724	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,014,251	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,715,649	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,944	4,944	40,236	382,852	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	484,157	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,864	591,864	5,740,777	31,372,779	-1,139,220	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	174	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	16,396	0	0	194.01
194.02	07952	TENANT LEASED SPACE	136,956	0	0	0	0	194.02
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)	445,608	156,169	1,001,720	143,086		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.611410	0.263860	0.173990	0.004561		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,574	13,283		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000447	0.000423		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUN)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	8,932,739					5.02
7.00	00700	OPERATION OF PLANT	850,225	519,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,205	0	67,239			8.00
9.00	00900	HOUSEKEEPING	165,396	14,424	0	368,484		9.00
10.00	01000	DIETARY	509,224	0	0	0	39,106	10.00
11.00	01100	CAFETERIA	75,858	55,728	0	55,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	806,387	1,560	0	1,560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,390	11,016	0	11,016	0	14.00
15.00	01500	PHARMACY	126,505	4,668	0	4,668	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,962	5,352	0	5,352	0	16.00
17.00	01700	SOCIAL SERVICE	3,035	3,468	0	3,468	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,076,022	92,796	37,716	92,796	39,106	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,100	5,160	0	5,160	0	54.00
60.00	06000	LABORATORY	54,198	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,518	1,200	0	1,200	0	65.00
66.00	06600	PHYSICAL THERAPY	842,152	121,092	14,001	121,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,044,866	57,168	15,522	57,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	428,474	4,332	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	527	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,387	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	257,592	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	57,275	4,944	0	4,944	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	86,758	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,811,056	382,908	67,239	368,484	39,106	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,818	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	32,129	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	83,736	136,956	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,139,220	958,657	91,561	213,088	574,167	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.127533	1.844053	1.361725	0.578283	14.682325	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,303	121,741	457	16,981	2,996	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005631	0.234179	0.006797	0.046083	0.076612	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES-NURS AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,989					11.00
13.00	01300	NURSING ADMINISTRATION	853	2,310,319				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36	0	116,542			14.00
15.00	01500	PHARMACY	89	88,528	0	236,084		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252	0	1,125	0	31,372,779	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,652	2,190,665	95,364	0	11,008,701	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	242,230	54.00
60.00	06000	LABORATORY	68	21,040	598	0	975,230	60.00
65.00	06500	RESPIRATORY THERAPY	15	10,004	1,434	0	29,798	65.00
66.00	06600	PHYSICAL THERAPY	753	0	6,494	0	4,762,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	881	0	7,704	0	5,030,708	67.00
68.00	06800	SPEECH PATHOLOGY	322	0	1,350	0	2,688,266	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82	0	0	38,724	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,014,251	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	236,084	4,715,649	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	42	0	158	0	382,852	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	484,157	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,963	2,310,319	114,227	236,084	31,372,779	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	44	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	26	0	2,271	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
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)	220,524	939,922	64,341	192,770	315,779	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.553012	0.406836	0.552084	0.816531	0.010065	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,848	14,536	13,252	7,529	10,194	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.278581	0.006292	0.113710	0.031891	0.000325	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:23 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS %)	
			17.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	6,461	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	6,461	30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	76.01
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,461	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	194.01
194.02	07952	TENANT LEASED SPACE	0	194.02
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)	11,822	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.829748	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,024	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.622814	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,500,388		5,500,388	0	5,500,388	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,708		29,708	0	29,708	54.00
60.00	06000	LABORATORY	81,962		81,962	0	81,962	60.00
65.00	06500	RESPIRATORY THERAPY	28,294	0	28,294	0	28,294	65.00
66.00	06600	PHYSICAL THERAPY	1,337,223	0	1,337,223	0	1,337,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,423	0	1,420,423	0	1,420,423	67.00
68.00	06800	SPEECH PATHOLOGY	531,574	0	531,574	0	531,574	68.00
69.00	06900	ELECTROCARDIOLOGY	1,017		1,017	0	1,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,323		34,323	0	34,323	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,676		530,676	0	530,676	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,820		81,820	0	81,820	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	102,696		102,696	0	102,696	76.01
200.00		Subtotal (see instructions)	9,680,104	0	9,680,104	0	9,680,104	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	9,680,104	0	9,680,104	0	9,680,104	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,008,701		11,008,701			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	242,230	0	242,230	0.122644	0.000000	54.00
60.00	06000	LABORATORY	975,230	0	975,230	0.084044	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	29,798	0	29,798	0.949527	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,762,213	0	4,762,213	0.280799	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,009,162	21,546	5,030,708	0.282351	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,688,266	0	2,688,266	0.197739	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,724	0	38,724	0.026263	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,014,251	0	1,014,251	0.033841	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,715,649	0	4,715,649	0.112535	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	382,852	0	382,852	0.213712	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	484,157	0	484,157	0.212113	0.000000	76.01
200.00		Subtotal (see instructions)	31,351,233	21,546	31,372,779			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,351,233	21,546	31,372,779			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 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
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122644		54.00
60.00	06000	LABORATORY	0.084044		60.00
65.00	06500	RESPIRATORY THERAPY	0.949527		65.00
66.00	06600	PHYSICAL THERAPY	0.280799		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.282351		67.00
68.00	06800	SPEECH PATHOLOGY	0.197739		68.00
69.00	06900	ELECTROCARDIOLOGY	0.026263		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033841		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112535		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213712		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.212113		76.01
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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,500,388		5,500,388	0	5,500,388	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,708		29,708	0	29,708	54.00
60.00	06000	LABORATORY	81,962		81,962	0	81,962	60.00
65.00	06500	RESPIRATORY THERAPY	28,294	0	28,294	0	28,294	65.00
66.00	06600	PHYSICAL THERAPY	1,337,223	0	1,337,223	0	1,337,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,423	0	1,420,423	0	1,420,423	67.00
68.00	06800	SPEECH PATHOLOGY	531,574	0	531,574	0	531,574	68.00
69.00	06900	ELECTROCARDIOLOGY	1,017		1,017	0	1,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,323		34,323	0	34,323	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,676		530,676	0	530,676	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,820		81,820	0	81,820	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	102,696		102,696	0	102,696	76.01
200.00		Subtotal (see instructions)	9,680,104	0	9,680,104	0	9,680,104	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	9,680,104	0	9,680,104	0	9,680,104	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,008,701		11,008,701			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	242,230	0	242,230	0.122644	0.000000	54.00
60.00	06000	LABORATORY	975,230	0	975,230	0.084044	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	29,798	0	29,798	0.949527	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,762,213	0	4,762,213	0.280799	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,009,162	21,546	5,030,708	0.282351	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,688,266	0	2,688,266	0.197739	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,724	0	38,724	0.026263	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,014,251	0	1,014,251	0.033841	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,715,649	0	4,715,649	0.112535	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	382,852	0	382,852	0.213712	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	484,157	0	484,157	0.212113	0.000000	76.01
200.00		Subtotal (see instructions)	31,351,233	21,546	31,372,779			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,351,233	21,546	31,372,779			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122644		54.00
60.00	06000	LABORATORY	0.084044		60.00
65.00	06500	RESPIRATORY THERAPY	0.949527		65.00
66.00	06600	PHYSICAL THERAPY	0.280799		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.282351		67.00
68.00	06800	SPEECH PATHOLOGY	0.197739		68.00
69.00	06900	ELECTROCARDIOLOGY	0.026263		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033841		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112535		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213712		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.212113		76.01
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,708	6,218	23,490	0	0	54.00
60.00	06000	LABORATORY	81,962	1,875	80,087	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,294	1,878	26,416	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,337,223	156,296	1,180,927	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,423	85,205	1,335,218	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	531,574	12,715	518,859	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,017	33	984	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,323	879	33,444	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,676	12,508	518,168	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,820	6,749	75,071	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	102,696	851	101,845	0	0	76.01
200.00		Subtotal (sum of lines 50 thru 199)	4,179,716	285,207	3,894,509	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,179,716	285,207	3,894,509	0	0	202.00

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

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,708	242,230	0.122644		54.00
60.00	06000	LABORATORY	81,962	975,230	0.084044		60.00
65.00	06500	RESPIRATORY THERAPY	28,294	29,798	0.949527		65.00
66.00	06600	PHYSICAL THERAPY	1,337,223	4,762,213	0.280799		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,423	5,030,708	0.282351		67.00
68.00	06800	SPEECH PATHOLOGY	531,574	2,688,266	0.197739		68.00
69.00	06900	ELECTROCARDIOLOGY	1,017	38,724	0.026263		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,323	1,014,251	0.033841		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,676	4,715,649	0.112535		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,820	382,852	0.213712		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	102,696	484,157	0.212113		76.01
200.00		Subtotal (sum of lines 50 thru 199)	4,179,716	20,364,078			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	4,179,716	20,364,078			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/28/2018 4:23 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	199,564	0	199,564	6,461	30.89	30.00
200.00	Total (lines 30 through 199)	199,564		199,564	6,461		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,601	80,345	30.00
200.00	Total (lines 30 through 199)	2,601	80,345	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/28/2018 4:23 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,218	242,230	0.025670	173,566	4,455	54.00
60.00	06000	LABORATORY	1,875	975,230	0.001923	411,733	792	60.00
65.00	06500	RESPIRATORY THERAPY	1,878	29,798	0.063024	2,113	133	65.00
66.00	06600	PHYSICAL THERAPY	156,296	4,762,213	0.032820	1,932,434	63,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,205	5,030,708	0.016937	2,020,520	34,222	67.00
68.00	06800	SPEECH PATHOLOGY	12,715	2,688,266	0.004730	968,047	4,579	68.00
69.00	06900	ELECTROCARDIOLOGY	33	38,724	0.000852	22,180	19	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	879	1,014,251	0.000867	289,337	251	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,508	4,715,649	0.002652	1,863,190	4,941	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,749	382,852	0.017628	119,936	2,114	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	851	484,157	0.001758	285,168	501	76.01
200.00		Total (lines 50 through 199)	285,207	20,364,078		8,088,224	115,429	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/28/2018 4:23 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
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,461	0.00	2,601	30.00
200.00		Total (lines 30 through 199)		0	6,461		2,601	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:23 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/28/2018 4:23 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	242,230	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	975,230	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,762,213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,030,708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,688,266	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,724	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,014,251	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,715,649	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	382,852	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	484,157	0.000000	76.01
200.00		Total (lines 50 through 199)	0	0	0	20,364,078		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:23 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	173,566	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	411,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,113	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,932,434	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,020,520	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	968,047	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,180	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	289,337	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,863,190	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	119,936	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.000000	285,168	0	0	0	76.01
200.00		Total (lines 50 through 199)		8,088,224	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	199,564	0	199,564	6,461	30.89	30.00
200.00	Total (lines 30 through 199)	199,564		199,564	6,461		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	237	7,321				30.00
200.00	Total (lines 30 through 199)	237	7,321				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,218	242,230	0.025670	36,830	945	54.00
60.00	06000	LABORATORY	1,875	975,230	0.001923	31,501	61	60.00
65.00	06500	RESPIRATORY THERAPY	1,878	29,798	0.063024	11,267	710	65.00
66.00	06600	PHYSICAL THERAPY	156,296	4,762,213	0.032820	166,507	5,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,205	5,030,708	0.016937	189,620	3,212	67.00
68.00	06800	SPEECH PATHOLOGY	12,715	2,688,266	0.004730	115,458	546	68.00
69.00	06900	ELECTROCARDIOLOGY	33	38,724	0.000852	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	879	1,014,251	0.000867	82,583	72	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,508	4,715,649	0.002652	206,168	547	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,749	382,852	0.017628	23,340	411	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	851	484,157	0.001758	0	0	76.01
200.00		Total (lines 50 through 199)	285,207	20,364,078		863,274	11,969	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | 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
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,461	0.00	237	30.00
200.00		Total (lines 30 through 199)		0	6,461		237	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	242,230	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	975,230	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,762,213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,030,708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,688,266	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,724	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,014,251	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,715,649	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	382,852	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	484,157	0.000000	76.01
200.00		Total (lines 50 through 199)	0	0	0	20,364,078		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	36,830	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	31,501	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	11,267	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	166,507	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	189,620	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	115,458	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	82,583	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	206,168	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	23,340	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.000000	0	0	0	0	76.01
200.00		Total (lines 50 through 199)		863,274	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:23 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,461	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,461	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)	6,461	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,601	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)	5,500,388	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)	5,500,388	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,500,388	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)	851.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,214,283	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)	2,214,283	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:23 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,668,608	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,882,891	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)	80,345	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	115,429	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	195,774	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,687,117	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:23 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	199,564	5,500,388	0.036282	0	0	90.00
91.00	Nursing School cost	0	5,500,388	0.000000	0	0	91.00
92.00	Allied health cost	0	5,500,388	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,500,388	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,461	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,461	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)	6,461	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)	237	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)	5,500,388	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)	5,500,388	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,500,388	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)	851.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	201,763	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)	201,763	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	171,971	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	373,734	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)	7,321	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,969	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	19,290	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	354,444	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	199,564	5,500,388	0.036282	0	0	90.00
91.00	Nursing School cost	0	5,500,388	0.000000	0	0	91.00
92.00	Allied health cost	0	5,500,388	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,500,388	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 4:23 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		4,461,237		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122644	173,566	21,287	54.00
60.00	06000	LABORATORY	0.084044	411,733	34,604	60.00
65.00	06500	RESPIRATORY THERAPY	0.949527	2,113	2,006	65.00
66.00	06600	PHYSICAL THERAPY	0.280799	1,932,434	542,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.282351	2,020,520	570,496	67.00
68.00	06800	SPEECH PATHOLOGY	0.197739	968,047	191,421	68.00
69.00	06900	ELECTROCARDIOLOGY	0.026263	22,180	583	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033841	289,337	9,791	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112535	1,863,190	209,674	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213712	119,936	25,632	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.212113	285,168	60,488	76.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,088,224	1,668,608	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)		8,088,224		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 4:23 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		458,832		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122644	36,830	4,517	54.00
60.00	06000	LABORATORY	0.084044	31,501	2,647	60.00
65.00	06500	RESPIRATORY THERAPY	0.949527	11,267	10,698	65.00
66.00	06600	PHYSICAL THERAPY	0.280799	166,507	46,755	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.282351	189,620	53,539	67.00
68.00	06800	SPEECH PATHOLOGY	0.197739	115,458	22,831	68.00
69.00	06900	ELECTROCARDIOLOGY	0.026263	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.033841	82,583	2,795	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112535	206,168	23,201	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213712	23,340	4,988	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.212113	0	0	76.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		863,274	171,971	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)		863,274		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2018 4:23 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		4,384,330		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)		4,384,330		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		54,212		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,438,542		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	Provider CCN: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part III Date/Time Prepared: 2/28/2018 4:23 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,147,444	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0262	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	235,160	3.00
4.00	Outlier Payments	195,338	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	17.701370	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,577,942	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,577,942	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,577,942	19.00
20.00	Deductibles	19,600	20.00
21.00	Subtotal (line 19 minus line 20)	4,558,342	21.00
22.00	Coinsurance	29,218	22.00
23.00	Subtotal (line 21 minus line 22)	4,529,124	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,529,124	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,529,124	32.00
32.01	Sequestration adjustment (see instructions)	90,582	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,384,330	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	54,212	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	23,643	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	195,338	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2018 4:23 pm
	Title XIX	Hospital	PPS

		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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	863,274	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)	863,274	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)	863,274	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	863,274	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/28/2018 4:23 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	-35,914	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	2,139,761	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-443,923	0	0	0	6.00
7.00	Inventory	24,908	0	0	0	7.00
8.00	Prepaid expenses	33,965	0	0	0	8.00
9.00	Other current assets	48	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,718,845	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	900,000	0	0	0	12.00
13.00	Land improvements	276,453	0	0	0	13.00
14.00	Accumulated depreciation	-136,315	0	0	0	14.00
15.00	Buildings	11,624,396	0	0	0	15.00
16.00	Accumulated depreciation	-2,534,021	0	0	0	16.00
17.00	Leasehold improvements	369,719	0	0	0	17.00
18.00	Accumulated depreciation	-95,240	0	0	0	18.00
19.00	Fixed equipment	156,727	0	0	0	19.00
20.00	Accumulated depreciation	-60,749	0	0	0	20.00
21.00	Automobiles and trucks	113,428	0	0	0	21.00
22.00	Accumulated depreciation	-110,827	0	0	0	22.00
23.00	Major movable equipment	418,564	0	0	0	23.00
24.00	Accumulated depreciation	-154,165	0	0	0	24.00
25.00	Minor equipment depreciable	301,775	0	0	0	25.00
26.00	Accumulated depreciation	-256,177	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)	10,813,568	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	550,164	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	550,164	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,082,577	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	224,817	0	0	0	37.00
38.00	Salaries, wages, and fees payable	529,503	0	0	0	38.00
39.00	Payroll taxes payable	64,168	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	16,278,871	0	0	0	43.00
44.00	Other current liabilities	194,851	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,292,210	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,292,210	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-4,209,633				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)	-4,209,633	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,082,577	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/28/2018 4:23 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		-3,916,848		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-472,335				2.00
3.00	Total (sum of line 1 and line 2)		-4,389,183		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)		-4,389,183		0		11.00
12.00	ADJUSTMENTS	-179,550		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)		-179,550		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,209,633		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	ADJUSTMENTS		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: 15-3030 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2018 4:23 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,008,701		11,008,701	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,008,701		11,008,701	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,008,701		11,008,701	17.00
18.00	Ancillary services	20,342,532	21,546	20,364,078	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,351,233	21,546	31,372,779	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		10,257,509		29.00
30.00	ROUNDING	3			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)		3		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)		10,257,512		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prepared: 2/28/2018 4:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	31,372,779	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,497,827	2.00
3.00	Net patient revenues (line 1 minus line 2)	9,874,952	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,257,512	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-382,560	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 OPERATING REVENUE	-89,775	24.00
25.00	Total other income (sum of lines 6-24)	-89,775	25.00
26.00	Total (line 5 plus line 25)	-472,335	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)	-472,335	29.00