

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: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/29/2017 11:44 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/29/2017 Time: 11:44 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPH HOSPITAL & HEALTH CENTER (15-0010) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	56,721	-114,647	-34,282	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-16,724	6		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	39,997	-114,641	-34,282	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: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:55 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1907 WEST SYCAMORE STREET			PO Box:							1.00	
2.00	City: KOKOMO			State: IN		Zip Code: 46901		County:			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
				V	XVIII	XIX						
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		ST. JOSEPH HOSPITAL & HEALTH CENTER		150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		ST. JOSEPH ACUTE REHAB		15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2016		06/30/2017		20.00	
21.00	Type of Control (see instructions)						1				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y		Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								3		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPFS 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.			451	92	6	17	4,681	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.			7	1	0	0	128			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:55 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)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	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	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
	1.00	2.00	3.00				
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					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		Speech		Respiratory	
		1.00		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.					109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
						1.00 2.00 3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	523,776		0		0	
						1.00 2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:55 pm	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15H046		140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00	
142.00	Street: 10330 N MERIDIAN STREET	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
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.	Y				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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		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	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	
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	
168.01	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)					0.25	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:55 pm
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 3:55 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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	10/09/2017	Y	10/09/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 3:55 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 relieved 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.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD	HELMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3234	RONALD.HELMS@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 3:55 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.	MANAGER NET REVENUE MANAGEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	94	34,310	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)		94	34,310	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	13	4,745	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		107	39,055	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					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)		125				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	7,337	233	16,536			1.00
2.00 HMO and other (see instructions)	1,610	4,681				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	96	128				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)	7,337	233	16,536			7.00
8.00 INTENSIVE CARE UNIT	1,127	82	2,031			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		251	2,188			13.00
14.00 Total (see instructions)	8,464	566	20,755	0.00	658.27	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	2,430	8	3,285	0.00	18.52	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.)				0.00	0.00	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	676.79	27.00
28.00 Observation Bed Days		0	1,022			28.00
29.00 Ambulance Trips	2,203					29.00
30.00 Employee discount days (see instruction)			190			30.00
31.00 Employee discount days - IRF			23			31.00
32.00 Labor & delivery days (see instructions)	0	0	463			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,958	115	5,113	1.00
2.00 HMO and other (see instructions)			346	1,510		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,958	115	5,113	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	198	15	276	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.)	0.00					23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet S-3 Part II Date/Time Prepared: 11/28/2017 3:55 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	41,550,020	0	41,550,020	1,404,926.14	29.57	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		346,686	0	346,686	1,258.00	275.59	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		205,454	0	205,454	2,080.00	98.78	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		6,469,801	0	6,469,801	260,355.00	24.85	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,236,917	301,778	2,538,695	61,584.00	41.22	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		163,145	0	163,145	2,464.00	66.21	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		120,648	0	120,648	1,586.00	76.07	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		10,657,999	0	10,657,999	348,066.00	30.62	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		14,166,704	0	14,166,704			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		762,689	0	762,689			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		70,051	0	70,051			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		2,734,274	0	2,734,274			25.50
25.51	Related organization wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	450,170	0	450,170	4,805.00	93.69	26.00
27.00	Administrative & General	5.00	8,138,290	0	8,138,290	262,030.13	31.06	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2017 3:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	1,401,252	0	1,401,252	10,519.00	133.21	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	300,777	0	300,777	16,689.66	18.02	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	1,447,683	0	1,447,683	68,525.86	21.13	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	679,558	0	679,558	29,343.98	23.16	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,227,988	0	1,227,988	42,048.99	29.20	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	1,822,877	0	1,822,877	46,105.82	39.54	40.00
41.00	Medical Records & Medical Records Library	1,020,099	0	1,020,099	45,059.06	22.64	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2017 3:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	38,403,258	0	38,403,258	1,250,879.98	30.70	1.00
2.00	Excluded area salaries (see instructions)	2,236,917	301,778	2,538,695	61,584.00	41.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,166,341	-301,778	35,864,563	1,189,295.98	30.16	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,941,792	0	10,941,792	352,116.00	31.07	4.00
5.00	Subtotal wage-related costs (see inst.)	16,900,978	0	16,900,978	0.00	47.12	5.00
6.00	Total (sum of lines 3 thru 5)	64,009,111	-301,778	63,707,333	1,541,411.98	41.33	6.00
7.00	Total overhead cost (see instructions)	16,488,694	0	16,488,694	525,127.50	31.40	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2017 3:55 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,976,867	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		476,610	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		8,078,828	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		22,193	9.00
10.00	Dental, Hearing and Vision Plan		83,999	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		43,219	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		263,372	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		36,324	14.00
15.00	'Workers' Compensation Insurance		234,288	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,886,025	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		15,470	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		49,509	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		14,166,704	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/28/2017 3:55 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/28/2017 3:55 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.233195	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			7,488,613	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			75,906,374	6.00	
7.00	Medicaid cost (line 1 times line 6)			17,700,987	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			10,212,374	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			10,212,374	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,793,012	4,525,255	13,318,267	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,050,486	4,525,255	6,575,741	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	65,212	210,045	275,257	22.00	
23.00	Cost of charity care (line 21 minus line 22)	1,985,274	4,315,210	6,300,484	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,383,271	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			293,068	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			450,874	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			3,932,397	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,074,821	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			7,375,305	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,587,679	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		2,539,527	2,539,527	970,116	3,509,643	1.00
2.00	00200		1,987,368	1,987,368	292,734	2,280,102	2.00
4.00	00400		8,876,373	9,326,543	-19,492	9,307,051	4.00
5.00	00500	450,170	21,827,557	29,965,847	-45,194	29,920,653	5.00
7.00	00700	300,777	6,617,703	6,918,480	0	6,918,480	7.00
8.00	00800	0	0	0	494,618	494,618	8.00
9.00	00900	0	2,083,463	2,083,463	-443,637	1,639,826	9.00
10.00	01000	0	2,522,565	2,522,565	-1,540,651	981,914	10.00
11.00	01100	0	0	0	1,540,219	1,540,219	11.00
13.00	01300	1,227,988	305,714	1,533,702	-57,394	1,476,308	13.00
15.00	01500	1,822,877	4,030,506	5,853,383	12,135,189	17,988,572	15.00
16.00	01600	1,020,099	592,484	1,612,583	-124	1,612,459	16.00
22.00	02200	0	8,406	8,406	-8,406	0	22.00
23.00	02300	87,412	38,202	125,614	320,332	445,946	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,687,273	1,412,097	7,099,370	302,604	7,401,974	30.00
31.00	03100	1,341,230	252,758	1,593,988	-146,788	1,447,200	31.00
41.00	04100	1,042,881	129,025	1,171,906	-25,712	1,146,194	41.00
43.00	04300	0	0	0	567,337	567,337	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,582,408	6,768,883	10,351,291	-4,039,638	6,311,653	50.00
52.00	05200	2,254,221	470,532	2,724,753	-1,297,035	1,427,718	52.00
53.00	05300	0	10,604	10,604	0	10,604	53.00
54.00	05400	1,613,479	1,039,738	2,653,217	-368,404	2,284,813	54.00
54.01	03630	335,052	66,737	401,789	-35,988	365,801	54.01
56.00	05600	400,910	472,676	873,586	0	873,586	56.00
57.00	05700	305,967	32,072	338,039	-3,134	334,905	57.00
58.00	05800	293,011	35,274	328,285	-10,455	317,830	58.00
59.00	05900	94,836	220,605	315,441	-114,337	201,104	59.00
60.00	06000	0	5,521,223	5,521,223	-127,357	5,393,866	60.00
65.00	06500	1,308,509	314,747	1,623,256	-33,898	1,589,358	65.00
66.00	06600	3,131,478	1,092,498	4,223,976	-1,533,136	2,690,840	66.00
67.00	06700	0	0	0	1,010,198	1,010,198	67.00
68.00	06800	0	0	0	154,653	154,653	68.00
69.00	06900	650,573	243,171	893,744	-149,417	744,327	69.00
70.00	07000	357,956	234,872	592,828	-106,274	486,554	70.00
71.00	07100	548,531	189,639	738,170	1,946,471	2,684,641	71.00
72.00	07200	0	0	0	3,406,033	3,406,033	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	221,280	221,280	-2,658	218,622	74.00
76.00	03550	1,353,188	583,989	1,937,177	-10,403	1,926,774	76.00
76.01	03190	648,498	16,133,078	16,781,576	-12,068,664	4,712,912	76.01
76.02	03330	173,357	215,080	388,437	-67,852	320,585	76.02
76.03	03950	266,885	712,378	979,263	-89,361	889,902	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,005,540	440,843	2,446,383	-199,815	2,246,568	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	762,037	179,067	941,104	-36,566	904,538	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		558,714	558,714	-558,714	0	113.00
115.00	11500	0	0	0	0	0	115.00
118.00		41,205,433	88,981,448	130,186,881	0	130,186,881	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	1,103,997	1,103,997	0	1,103,997	192.00
192.01	19201	0	36,708	36,708	0	36,708	192.01
192.02	19202	0	18,429	18,429	0	18,429	192.02
192.03	19203	0	914,664	914,664	0	914,664	192.03
194.00	07950	0	584	584	0	584	194.00
194.01	07951	0	11,486	11,486	0	11,486	194.01
194.02	07952	344,587	78,004	422,591	0	422,591	194.02
200.00		41,550,020	91,145,320	132,695,340	0	132,695,340	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A
Date/Time Prepared:
11/28/2017 3:55 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	-538,351	2,971,292	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,280,102	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-340,143	8,966,908	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,632,036	23,288,617	5.00
7.00	00700	OPERATION OF PLANT	-72,204	6,846,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	494,618	8.00
9.00	00900	HOUSEKEEPING	0	1,639,826	9.00
10.00	01000	DIETARY	-40,259	941,655	10.00
11.00	01100	CAFETERIA	-597,367	942,852	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,476,308	13.00
15.00	01500	PHARMACY	-17,661	17,970,911	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-382	1,612,077	16.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	ALLIED HEALTH-RAD TECH	-23,375	422,571	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-460,770	6,941,204	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,447,200	31.00
41.00	04100	SUBPROVIDER - I RF	0	1,146,194	41.00
43.00	04300	NURSERY	0	567,337	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,311,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-618	1,427,100	52.00
53.00	05300	ANESTHESIOLOGY	0	10,604	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-71,415	2,213,398	54.00
54.01	03630	ULTRA SOUND	0	365,801	54.01
56.00	05600	RADIOISOTOPE	0	873,586	56.00
57.00	05700	CT SCAN	0	334,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	317,830	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	201,104	59.00
60.00	06000	LABORATORY	0	5,393,866	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,589,358	65.00
66.00	06600	PHYSICAL THERAPY	-36,344	2,654,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,010,198	67.00
68.00	06800	SPEECH PATHOLOGY	0	154,653	68.00
69.00	06900	ELECTROCARDIOLOGY	0	744,327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	486,554	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,684,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,406,033	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	218,622	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-642,730	1,284,044	76.00
76.01	03190	CHEMOTHERAPY	-19,123	4,693,789	76.01
76.02	03330	ENDOSCOPY	0	320,585	76.02
76.03	03950	WOUND CARE CENTER	-2,923	886,979	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	2,246,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-50	904,488	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,495,751	120,691,130	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,103,997	192.00
192.01	19201	ASC MOB	0	36,708	192.01
192.02	19202	EDUCATION CENTER	0	18,429	192.02
192.03	19203	MARKETING	669,586	1,584,250	192.03
194.00	07950	FOUNDATION	0	584	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	11,486	194.01
194.02	07952	CLINIC OF HOPE	0	422,591	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,826,165	123,869,175	200.00

RECLASSIFICATIONS

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Period:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE STORAGE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	363,522	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	363,522	
B - RENTAL EXPENSE EQUIPMENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	292,734	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,398	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
TOTALS			0	295,132	
C - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	314,388	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
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
TOTALS			0	314,388	
D - REAL ESTATE TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	55,591	1.00
TOTALS			0	55,591	
E - LAUNDRY EXPENSE RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	494,618	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
TOTALS			0	494,618	
F - CAFETERIA DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	1,540,219	1.00
TOTALS			0	1,540,219	
G - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	551,003	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,711	2.00
TOTALS			0	558,714	
H - LD_AP_NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	512,386	106,952	1.00
2.00	NURSERY	43.00	469,365	97,972	2.00
TOTALS			981,751	204,924	
I - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,011,150	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	TOTALS		0	2,011,150		
J - PT_OT_ST RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	748,895	261,303		1.00
2.00	SPEECH PATHOLOGY	68.00	114,653	40,000		2.00
	TOTALS		863,548	301,303		
K - CHEMOTHERAPY SUPPLIES						
1.00	PHARMACY	15.00	0	11,988,813		1.00
	TOTALS		0	11,988,813		
L - IMPLANTABLE SUPPLIES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,406,033		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
	TOTALS		0	3,406,033		
M - RADIOLOGY TECH PRECEPTING RECLASS						
1.00	ALLIED HEALTH-RAD TECH	23.00	301,778	23,086		1.00
	TOTALS		301,778	23,086		
N - MEDICAL EDUCATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,406		1.00
	TOTALS		0	8,406		
500.00	Grand Total: Increases		2,147,077	21,565,899		500.00

RECLASSIFICATIONS

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Period:
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To 06/30/2017

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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - RENTAL EXPENSE STORAGE							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	10,403	10		1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	72,678	0		2.00
3.00	WOUND CARE CENTER	76.03	0	2,557	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	102,718	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	38,457	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	129,110	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,599	0		7.00
	TOTALS		0	363,522			
B - RENTAL EXPENSE EQUIPMENT							
1.00	NURSING ADMINISTRATION	13.00	0	54,874	10		1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,880	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	4,276	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	33,144	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	38,015	0		5.00
6.00	PHARMACY	15.00	0	157,943	0		6.00
	TOTALS		0	295,132			
C - DRUGS CHARGED TO PATIENTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,208	0		1.00
2.00	ALLIED HEALTH-RAD TECH	23.00	0	4,532	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	17,734	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	4,696	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	367	0		5.00
6.00	OPERATING ROOM	50.00	0	48,670	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	10,898	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,246	0		8.00
9.00	CT SCAN	57.00	0	10	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	9,135	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	3,780	0		11.00
12.00	LABORATORY	60.00	0	6,207	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	19,365	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	127,101	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,111	0		15.00
16.00	RENAL DIALYSIS	74.00	0	851	0		16.00
17.00	CHEMOTHERAPY	76.01	0	2,589	0		17.00
18.00	ENDOSCOPY	76.02	0	3,296	0		18.00
19.00	WOUND CARE CENTER	76.03	0	12,477	0		19.00
20.00	EMERGENCY	91.00	0	6,675	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	9,686	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	754	0		22.00
	TOTALS		0	314,388			
D - REAL ESTATE TAXES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55,591	13		1.00
	TOTALS		0	55,591			
E - LAUNDRY EXPENSE RECLASS							
1.00	HOUSEKEEPING	9.00	0	443,489	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,203	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	13,978	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	15,939	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	11,842	0		5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,167	0		6.00
	TOTALS		0	494,618			
F - CAFETERIA DIETARY RECLASS							
1.00	DIETARY	10.00	0	1,540,219	0		1.00
	TOTALS		0	1,540,219			
G - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	558,714	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	558,714			
H - LD_AP_NURSERY RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	981,751	204,924	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		981,751	204,924			
I - MEDICAL SUPPLIES CHARGED TO PATIENTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	284	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,118	0		2.00
3.00	HOUSEKEEPING	9.00	0	148	0		3.00
4.00	DIETARY	10.00	0	432	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,520	0		5.00
6.00	PHARMACY	15.00	0	9,938	0		6.00

RECLASSIFICATIONS

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Period:
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Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	124	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	298,730	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	141,989	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	25,345	0		10.00
11.00	OPERATING ROOM	50.00	0	729,084	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	99,331	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,391	0		13.00
14.00	ULTRA SOUND	54.01	0	35,988	0		14.00
15.00	CT SCAN	57.00	0	3,124	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,320	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	24,970	0		17.00
18.00	LABORATORY	60.00	0	121,150	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	32,600	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	22,316	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	18,549	0		21.00
22.00	RENAL DIALYSIS	74.00	0	1,807	0		22.00
23.00	CHEMOTHERAPY	76.01	0	77,262	0		23.00
24.00	ENDOSCOPY	76.02	0	64,287	0		24.00
25.00	WOUND CARE CENTER	76.03	0	42,186	0		25.00
26.00	EMERGENCY	91.00	0	191,875	0		26.00
27.00	AMBULANCE SERVICES	95.00	0	26,282	0		27.00
TOTALS			0	2,011,150			
J - PT_OT_ST RECLASS							
1.00	PHYSICAL THERAPY	66.00	863,548	301,303	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			863,548	301,303			
K - CHEMOTHERAPY SUPPLIES							
1.00	CHEMOTHERAPY	76.01	0	11,988,813	0		1.00
TOTALS			0	11,988,813			
L - IMPLANTABLE SUPPLIES							
1.00	PHARMACY	15.00	0	131	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	270	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	103	0		3.00
4.00	OPERATING ROOM	50.00	0	3,261,884	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	131	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	101	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	85,587	0		7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	23,553	0		8.00
9.00	ENDOSCOPY	76.02	0	269	0		9.00
10.00	WOUND CARE CENTER	76.03	0	32,141	0		10.00
11.00	EMERGENCY	91.00	0	1,265	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	598	0		12.00
TOTALS			0	3,406,033			
M - RADIOLOGY TECH PRECEPTING RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	301,778	23,086	0		1.00
TOTALS			301,778	23,086			
N - MEDICAL EDUCATION RECLASS							
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	8,406	0		1.00
TOTALS			0	8,406			
500.00	Grand Total: Decreases		2,147,077	21,565,899			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part I
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	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	722,779	0	0	0	1.00
2.00	Land Improvements	1,764,978	0	0	0	2.00
3.00	Buildings and Fixtures	55,865,554	385,395	0	385,395	3.00
4.00	Building Improvements	9,712,068	57,456	0	57,456	4.00
5.00	Fixed Equipment	21,774,546	0	0	0	5.00
6.00	Movable Equipment	38,498,518	1,756,256	0	1,756,256	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	128,338,443	2,199,107	0	2,199,107	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	128,338,443	2,199,107	0	2,199,107	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	722,779	0			1.00
2.00	Land Improvements	1,764,978	0			2.00
3.00	Buildings and Fixtures	56,250,949	0			3.00
4.00	Building Improvements	9,658,467	0			4.00
5.00	Fixed Equipment	21,765,514	0			5.00
6.00	Movable Equipment	39,537,796	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	129,700,483	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	129,700,483	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
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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	2,539,527	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,987,368	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,526,895	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	2,539,527				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,987,368				2.00
3.00	Total (sum of lines 1-2)	0	4,526,895				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0010

Period:
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Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	90,162,687	0	90,162,687	0.695161	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,537,796	0	39,537,796	0.304839	0	2.00
3.00	Total (sum of lines 1-2)	129,700,483	0	129,700,483	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,552,179	363,522	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,987,368	292,734	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,539,547	656,256	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	0	0	55,591	0	2,971,292	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,280,102	2.00
3.00	Total (sum of lines 1-2)	0	0	55,591	0	5,251,394	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8

Date/Time Prepared:
11/28/2017 3:55 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)	B	-23,000		ADMINISTRATIVE & GENERAL	5.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-8,345		ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,135,202				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	3,191,999				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-597,367		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-17,661		PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-19,797		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OTHER MISCELLANEOUS REVENUE	B	-740		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01 OTHER MISCELLANEOUS REVENUE	B	-66,096		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8

Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.02 OTHER MISCELLANEOUS REVENUE	B	-112,510	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 OTHER MISCELLANEOUS REVENUE	B	-51,260	OPERATION OF PLANT	7.00	0	33.03
33.04 OTHER MISCELLANEOUS REVENUE	B	-20,462	DIETARY	10.00	0	33.04
33.05 OTHER MISCELLANEOUS REVENUE	B	-382	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06 OTHER MISCELLANEOUS REVENUE	B	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 OTHER MISCELLANEOUS REVENUE	B	-23,375	ALLIED HEALTH-RAD TECH	23.00	0	33.07
33.08 OTHER MISCELLANEOUS REVENUE	B	-13,580	ADULTS & PEDIATRICS	30.00	0	33.08
33.09 OTHER MISCELLANEOUS REVENUE	B	-303	DELIVERY ROOM & LABOR ROOM	52.00	0	33.09
33.10 OTHER MISCELLANEOUS REVENUE	B	-26,133	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11 OTHER MISCELLANEOUS REVENUE	B	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 OTHER MISCELLANEOUS REVENUE	B	-36,322	PHYSICAL THERAPY	66.00	0	33.12
33.13 OTHER MISCELLANEOUS REVENUE	B	-17,000	CHEMOTHERAPY	76.01	0	33.13
33.14 OTHER MISCELLANEOUS REVENUE	B	-2,923	WOUND CARE CENTER	76.03	0	33.14
33.15 OTHER MISCELLANEOUS REVENUE	B	-50	AMBULANCE SERVICES	95.00	0	33.15
34.00 INDIANA PROVIDER TAX	A	-6,390,155	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01 PATIENT TELEVISION UTILITIES	A	-3,533	OPERATION OF PLANT	7.00	0	34.01
34.02 CHARITABLE CONTRIBUTIONS	A	-1,406	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03 MARKETING	A	-315	DELIVERY ROOM & LABOR ROOM	52.00	0	34.03
34.04 MARKETING	A	-2,123	CHEMOTHERAPY	76.01	0	34.04
34.05 MARKETING	A	-22	PHYSICAL THERAPY	66.00	0	34.05
34.06 CORPORATE SPONSORSHIP	A	-595	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07 AHA LIFE CARRYFORWARD ADJUSTMENT	A	12,652	CAP REL COSTS-BLDG & FIXT	1.00	9	34.07
34.08 BAD DEBT EXPENSE	A	-2,919,657	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09 LATE FEE/PENALTIES	A	-379	ADMINISTRATIVE & GENERAL	5.00	0	34.09
34.10 INCENTIVE OVER ACCRUAL SALARY	A	38,397	ADMINISTRATIVE & GENERAL	5.00	0	34.10
34.11 INCENTIVE OVER ACCRUAL FICA	A	-20,429	ADMINISTRATIVE & GENERAL	5.00	0	34.11
34.12 LOBBYING OFFSET	A	-2,253	ADMINISTRATIVE & GENERAL	5.00	0	34.12
34.13 INVESTMENT INCOME	B	-548,068	CAP REL COSTS-BLDG & FIXT	1.00	11	34.13
34.14 INVESTMENT INCOME	B	-7,670	ADMINISTRATIVE & GENERAL	5.00	0	34.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,826,165				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: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:
11/28/2017 3:55 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 HOME OFFICE COSTS:					
1.00	7.00	OPERATION OF PLANT	MEDEXCEL	2,390,174	2,407,585 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SVH HOME OFFICE	10,291,290	7,409,087 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	AH-INTEREST EXPENSE	548,068	551,003 3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	AH-INTEREST EXPENSE	7,670	7,711 3.01
3.02	192.03	MARKETING	SVH MARKETING	669,586	0 3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	6,587,466	6,926,869 3.03
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	1,110,391	1,110,391 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK SALARY	5,117,616	5,117,616 4.01
4.02	0.00			0	0 4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK OTHER	2,887,969	2,887,969 4.03
4.04	15.00	PHARMACY	SVH CHARGEBACK	-87,816	-87,816 4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	1,476,820	1,476,820 4.05
4.06	23.00	ALLIED HEALTH-RAD TECH	SVH CHARGEBACK	29,755	29,755 4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	96,510	96,510 4.07
4.08	58.00	MAGNETIC RESONANCE IMAGING (SVH CHARGEBACK	13,517	13,517 4.08
4.09	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	5,004	5,004 4.09
4.10	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	109,833	109,833 4.10
4.11	71.00	MEDICAL SUPPLIES CHARGED TO	SVH CHARGEBACK	359,903	359,903 4.11
4.12	76.01	CHEMOTHERAPY	SVH CHARGEBACK	6,000	6,000 4.12
4.13	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	1,023,176	1,023,176 4.13
4.14	194.02	CLINIC OF HOPE	SVH CHARGEBACK	1,900	1,900 4.14
5.00	TOTALS (sum of lines 1-4).			32,644,832	29,452,833 5.00
Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

* 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.

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

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

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

6.00	B		0.00	ASCENSION	100.00	6.00
7.00	B		0.00	STV HEALTH	100.00	7.00
8.00	A		0.00	MEDEXCEL	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(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: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:
11/28/2017 3:55 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	-17,411	0		1.00
2.00	2,882,203	0		2.00
3.00	-2,935	11		3.00
3.01	-41	0		3.01
3.02	669,586	0		3.02
3.03	-339,403	0		3.03
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	3,191,999			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-2

Date/Time Prepared:
11/28/2017 3:55 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	DR. A	33,000	33,000	0	0	0	1.00
2.00	76.00	DR. B	12,800	12,800	0	0	0	2.00
3.00	76.00	DR. C	330,012	330,012	0	0	0	3.00
4.00	76.00	DR. D	65,023	65,023	0	0	0	4.00
5.00	54.00	DR. E	45,282	45,282	0	0	0	5.00
6.00	30.00	DR. F	468,000	358,000	110,000	181,300	1,624	6.00
7.00	76.00	DR. G	27,200	27,200	0	0	0	7.00
8.00	5.00	DR. H	126,000	0	126,000	246,400	1,260	8.00
9.00	5.00	DR. I	327,600	0	327,600	246,400	3,276	9.00
10.00	30.00	DR. J	71,879	0	71,879	181,300	180	10.00
11.00	76.00	DR. K	8,081	0	8,081	181,300	67	11.00
12.00	76.00	DR. L	205,454	205,454	0	0	0	12.00
200.00			1,720,331	1,076,771	643,560		6,407	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	DR. A	0	0	0	0	0	1.00
2.00	76.00	DR. B	0	0	0	0	0	2.00
3.00	76.00	DR. C	0	0	0	0	0	3.00
4.00	76.00	DR. D	0	0	0	0	0	4.00
5.00	54.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	141,553	7,078	0	0	0	6.00
7.00	76.00	DR. G	0	0	0	0	0	7.00
8.00	5.00	DR. H	149,261	7,463	0	0	0	8.00
9.00	5.00	DR. I	388,080	19,404	0	0	0	9.00
10.00	30.00	DR. J	15,689	784	0	0	0	10.00
11.00	76.00	DR. K	5,840	292	0	0	0	11.00
12.00	76.00	DR. L	0	0	0	0	0	12.00
200.00			700,423	35,021	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	DR. A	0	0	0	33,000	1.00
2.00	76.00	DR. B	0	0	0	12,800	2.00
3.00	76.00	DR. C	0	0	0	330,012	3.00
4.00	76.00	DR. D	0	0	0	65,023	4.00
5.00	54.00	DR. E	0	0	0	45,282	5.00
6.00	30.00	DR. F	0	141,553	0	358,000	6.00
7.00	76.00	DR. G	0	0	0	27,200	7.00
8.00	5.00	DR. H	0	149,261	0	0	8.00
9.00	5.00	DR. I	0	388,080	0	0	9.00
10.00	30.00	DR. J	0	15,689	56,190	56,190	10.00
11.00	76.00	DR. K	0	5,840	2,241	2,241	11.00
12.00	76.00	DR. L	0	0	0	205,454	12.00
200.00			0	700,423	58,431	1,135,202	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,971,292	2,971,292			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,280,102		2,280,102		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,966,908	114,931	763	9,082,602	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	23,288,617	449,262	14,116	1,798,459	5.00
7.00 00700	OPERATION OF PLANT	6,846,276	412,301	214,060	66,468	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	494,618	4,644	0	0	8.00
9.00 00900	HOUSEKEEPING	1,639,826	18,064	5,470	0	9.00
10.00 01000	DIETARY	941,655	46,663	10,922	0	10.00
11.00 01100	CAFETERIA	942,852	56,569	17,125	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,476,308	48,958	185,158	271,372	13.00
15.00 01500	PHARMACY	17,970,911	28,679	460	402,836	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,612,077	21,937	7,620	225,431	16.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	ALLIED HEALTH-RAD TECH	422,571	8,033	0	86,007	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,941,204	263,966	153,589	1,370,056	30.00
31.00 03100	INTENSIVE CARE UNIT	1,447,200	50,527	9,524	296,397	31.00
41.00 04100	SUBPROVIDER - IRF	1,146,194	121,637	2,000	230,465	41.00
43.00 04300	NURSERY	567,337	14,425	17,431	103,725	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,311,653	292,699	263,565	791,673	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,427,100	29,262	47,255	281,202	52.00
53.00 05300	ANESTHESIOLOGY	10,604	0	33,648	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,213,398	231,486	668,183	289,871	54.00
54.01 03630	ULTRA SOUND	365,801	0	3,933	74,043	54.01
56.00 05600	RADIOISOTOPE	873,586	0	26,248	88,597	56.00
57.00 05700	CT SCAN	334,905	0	1,782	67,615	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	317,830	0	0	64,752	58.00
59.00 05900	CARDIAC CATHETERIZATION	201,104	3,586	2,503	20,958	59.00
60.00 06000	LABORATORY	5,393,866	70,824	3,978	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,589,358	11,090	0	289,166	65.00
66.00 06600	PHYSICAL THERAPY	2,654,496	64,683	90,183	501,188	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,010,198	27,756	29,785	165,498	67.00
68.00 06800	SPEECH PATHOLOGY	154,653	9,324	4,559	25,337	68.00
69.00 06900	ELECTROCARDIOLOGY	744,327	35,887	82,009	143,769	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	486,554	24,457	58,026	79,104	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,684,641	38,630	87,865	121,219	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,406,033	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	218,622	0	0	0	74.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,284,044	41,158	0	299,040	76.00
76.01 03190	CHEMOTHERAPY	4,693,789	0	9,905	143,311	76.01
76.02 03330	ENDOSCOPY	320,585	0	38,995	38,310	76.02
76.03 03950	WOUND CARE CENTER	886,979	26,895	7,169	58,979	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	2,246,568	173,383	45,257	443,202	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	904,488	35,573	129,579	168,402	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	120,691,130	2,777,289	2,272,665	9,006,452	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,225	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,103,997	183,164	6,745	0	192.00
192.01 19201	ASC MOB	36,708	0	0	0	192.01
192.02 19202	EDUCATION CENTER	18,429	0	0	0	192.02
192.03 19203	MARKETING	1,584,250	0	0	0	192.03
194.00 07950	FOUNDATION	584	1,614	91	0	194.00
194.01 07951	ASPR BIOTERRORISM GRANT	11,486	0	0	0	194.01
194.02 07952	CLINIC OF HOPE	422,591	0	601	76,150	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	123,869,175	2,971,292	2,280,102	9,082,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	25,550,454					5.00
7.00	00700	1,959,217	9,498,322				7.00
8.00	00800	129,745	22,112	651,119			8.00
9.00	00900	432,264	86,015	202,382	2,384,021		9.00
10.00	01000	259,676	222,188	0	0	1,481,104	10.00
11.00	01100	264,174	269,357	0	0	0	11.00
13.00	01300	515,017	233,116	0	1,825	0	13.00
15.00	01500	4,782,407	136,557	0	0	0	15.00
16.00	01600	485,202	104,456	0	608	0	16.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	134,254	38,248	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,268,392	1,256,887	210,490	764,262	1,018,782	30.00
31.00	03100	468,721	240,586	51,436	182,544	125,130	31.00
41.00	04100	389,888	579,182	20,499	182,544	202,389	41.00
43.00	04300	182,670	68,684	8,609	101,129	134,803	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,990,528	1,393,699	6,594	365,087	0	50.00
52.00	05200	463,828	139,332	23,338	175,108	0	52.00
53.00	05300	11,500	0	0	0	0	53.00
54.00	05400	884,335	1,102,230	14,579	37,117	0	54.00
54.01	03630	115,326	0	2,681	7,910	0	54.01
56.00	05600	256,868	0	0	27,382	0	56.00
57.00	05700	105,068	0	5,252	0	0	57.00
58.00	05800	99,423	0	1,267	0	0	58.00
59.00	05900	59,291	17,075	0	12,170	0	59.00
60.00	06000	1,421,165	337,230	486	75,451	0	60.00
65.00	06500	491,062	52,804	447	3,651	0	65.00
66.00	06600	860,326	307,989	0	8,811	0	66.00
67.00	06700	320,486	132,160	0	4,125	0	67.00
68.00	06800	50,383	44,395	412	8,361	0	68.00
69.00	06900	261,431	170,878	0	4,868	0	69.00
70.00	07000	168,435	116,451	0	31,032	0	70.00
71.00	07100	762,043	183,940	14,704	68,150	0	71.00
72.00	07200	885,139	0	46	0	0	72.00
73.00	07300	0	0	72	27,382	0	73.00
74.00	07400	56,814	0	0	12,170	0	74.00
76.00	03550	422,098	195,978	0	24,339	0	76.00
76.01	03190	1,259,611	0	0	0	0	76.01
76.02	03330	103,401	0	0	0	0	76.02
76.03	03950	254,682	128,062	0	38,943	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	755,820	825,574	79,226	219,052	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	321,735	169,383	8,599	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
115.00	11500	0	0	0	0	0	115.00
118.00		24,652,425	8,574,568	651,119	2,384,021	1,481,104	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,397	43,925	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	336,253	872,145	0	0	0	192.00
192.01	19201	9,539	0	0	0	0	192.01
192.02	19202	4,789	0	0	0	0	192.02
192.03	19203	411,705	0	0	0	0	192.03
194.00	07950	595	7,684	0	0	0	194.00
194.01	07951	2,985	0	0	0	0	194.01
194.02	07952	129,766	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		25,550,454	9,498,322	651,119	2,384,021	1,481,104	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	
	11.00	13.00	15.00	16.00	22.00	
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100	1,550,077					11.00
13.00 01300	31,357	2,763,111				13.00
15.00 01500	51,697	0	23,373,547			15.00
16.00 01600	51,555	0	0	2,508,886		16.00
22.00 02200	0	0	0	0	0	22.00
23.00 02300	20,134	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	360,978	1,075,885	0	150,336	0	30.00
31.00 03100	68,950	205,504	0	36,796	0	31.00
41.00 04100	62,422	186,048	0	25,353	0	41.00
43.00 04300	18,573	55,358	0	14,895	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	187,375	558,464	0	372,425	0	50.00
52.00 05200	56,215	167,546	0	64,357	0	52.00
53.00 05300	0	0	0	43,877	0	53.00
54.00 05400	65,234	0	0	88,722	0	54.00
54.01 03630	12,026	0	0	60,544	0	54.01
56.00 05600	0	0	0	82,777	0	56.00
57.00 05700	14,588	0	0	52,551	0	57.00
58.00 05800	14,210	0	0	14,404	0	58.00
59.00 05900	2,942	8,768	0	12,274	0	59.00
60.00 06000	0	0	0	326,953	0	60.00
65.00 06500	62,422	0	0	64,123	0	65.00
66.00 06600	107,121	0	0	69,684	0	66.00
67.00 06700	35,378	0	0	22,969	0	67.00
68.00 06800	5,416	0	0	3,517	0	68.00
69.00 06900	44,094	0	0	69,640	0	69.00
70.00 07000	17,923	0	0	29,659	0	70.00
71.00 07100	21,449	0	0	73,746	0	71.00
72.00 07200	0	0	0	66,467	0	72.00
73.00 07300	0	0	23,323,598	237,945	0	73.00
74.00 07400	0	0	0	967	0	74.00
76.00 03550	68,402	0	0	26,198	0	76.00
76.01 03190	49,387	147,195	0	55,817	0	76.01
76.02 03330	8,060	24,023	0	23,113	0	76.02
76.03 03950	15,405	45,915	0	78,190	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0	0	0	0	0	90.00
91.00 09100	96,764	288,405	0	299,001	0	91.00
92.00 09200						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	0	0	0	41,586	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
115.00 11500	0	0	0	0	0	115.00
118.00	1,550,077	2,763,111	23,323,598	2,508,886	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0	0	0	0	0	190.00
191.00 19100	0	0	0	0	0	191.00
192.00 19200	0	0	0	0	0	192.00
192.01 19201	0	0	0	0	0	192.01
192.02 19202	0	0	0	0	0	192.02
192.03 19203	0	0	0	0	0	192.03
194.00 07950	0	0	0	0	0	194.00
194.01 07951	0	0	0	0	0	194.01
194.02 07952	0	0	49,949	0	0	194.02
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	1,550,077	2,763,111	23,373,547	2,508,886	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	ALLIED HEALTH-RAD TECH	709,247			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,834,827	0	15,834,827
31.00	03100	INTENSIVE CARE UNIT	0	3,183,315	0	3,183,315
41.00	04100	SUBPROVIDER - I&R	0	3,148,621	0	3,148,621
43.00	04300	NURSERY	0	1,287,639	0	1,287,639
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,533,762	0	12,533,762
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,874,543	0	2,874,543
53.00	05300	ANESTHESIOLOGY	0	99,629	0	99,629
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,466	5,805,621	0	5,805,621
54.01	03630	ULTRA SOUND	143,612	785,876	0	785,876
56.00	05600	RADIOISOTOPE	196,350	1,551,808	0	1,551,808
57.00	05700	CT SCAN	124,652	706,413	0	706,413
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34,167	546,053	0	546,053
59.00	05900	CARDIAC CATHETERIZATION	0	340,671	0	340,671
60.00	06000	LABORATORY	0	7,629,953	0	7,629,953
65.00	06500	RESPIRATORY THERAPY	0	2,564,123	0	2,564,123
66.00	06600	PHYSICAL THERAPY	0	4,664,481	0	4,664,481
67.00	06700	OCCUPATIONAL THERAPY	0	1,748,355	0	1,748,355
68.00	06800	SPEECH PATHOLOGY	0	306,357	0	306,357
69.00	06900	ELECTROCARDIOLOGY	0	1,556,903	0	1,556,903
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,011,641	0	1,011,641
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,056,387	0	4,056,387
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,357,685	0	4,357,685
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,588,997	0	23,588,997
74.00	07400	RENAL DIALYSIS	0	288,573	0	288,573
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,361,257	0	2,361,257
76.01	03190	CHEMOTHERAPY	0	6,359,015	0	6,359,015
76.02	03330	ENDOSCOPY	0	556,487	0	556,487
76.03	03950	WOUND CARE CENTER	0	1,541,219	0	1,541,219
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	5,472,252	0	5,472,252
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,779,345	0	1,779,345
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	0	0
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	709,247	118,541,808	0	118,541,808
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	55,547	0	55,547
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,502,304	0	2,502,304
192.01	19201	ASC MOB	0	46,247	0	46,247
192.02	19202	EDUCATION CENTER	0	23,218	0	23,218
192.03	19203	MARKETING	0	1,995,955	0	1,995,955
194.00	07950	FOUNDATION	0	10,568	0	10,568
194.01	07951	ASPR BIOTERRORISM GRANT	0	14,471	0	14,471
194.02	07952	CLINIC OF HOPE	0	679,057	0	679,057
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	709,247	123,869,175	0	123,869,175

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	114,931	763	115,694	115,694 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,364,684	449,262	14,116	2,828,062	22,907 5.00
7.00 00700	OPERATION OF PLANT	0	412,301	214,060	626,361	847 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,644	0	4,644	0 8.00
9.00 00900	HOUSEKEEPING	0	18,064	5,470	23,534	0 9.00
10.00 01000	DIETARY	0	46,663	10,922	57,585	0 10.00
11.00 01100	CAFETERIA	0	56,569	17,125	73,694	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	48,958	185,158	234,116	3,457 13.00
15.00 01500	PHARMACY	0	28,679	460	29,139	5,131 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	21,937	7,620	29,557	2,872 16.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 02300	ALLIED HEALTH-RAD TECH	0	8,033	0	8,033	1,096 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	263,966	153,589	417,555	17,452 30.00
31.00 03100	INTENSIVE CARE UNIT	0	50,527	9,524	60,051	3,776 31.00
41.00 04100	SUBPROVIDER - I&R	0	121,637	2,000	123,637	2,936 41.00
43.00 04300	NURSERY	0	14,425	17,431	31,856	1,321 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	292,699	263,565	556,264	10,084 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	29,262	47,255	76,517	3,582 52.00
53.00 05300	ANESTHESIOLOGY	0	0	33,648	33,648	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	231,486	668,183	899,669	3,692 54.00
54.01 03630	ULTRA SOUND	0	0	3,933	3,933	943 54.01
56.00 05600	RADIOISOTOPE	0	0	26,248	26,248	1,129 56.00
57.00 05700	CT SCAN	0	0	1,782	1,782	861 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	825 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	3,586	2,503	6,089	267 59.00
60.00 06000	LABORATORY	0	70,824	3,978	74,802	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	11,090	0	11,090	3,683 65.00
66.00 06600	PHYSICAL THERAPY	0	64,683	90,183	154,866	6,384 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	27,756	29,785	57,541	2,108 67.00
68.00 06800	SPEECH PATHOLOGY	0	9,324	4,559	13,883	323 68.00
69.00 06900	ELECTROCARDIOLOGY	0	35,887	82,009	117,896	1,831 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	24,457	58,026	82,483	1,008 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,630	87,865	126,495	1,544 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	41,158	0	41,158	3,809 76.00
76.01 03190	CHEMOTHERAPY	0	0	9,905	9,905	1,826 76.01
76.02 03330	ENDOSCOPY	0	0	38,995	38,995	488 76.02
76.03 03950	WOUND CARE CENTER	0	26,895	7,169	34,064	751 76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	173,383	45,257	218,640	5,646 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	35,573	129,579	165,152	2,145 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,364,684	2,777,289	2,272,665	7,414,638	114,724 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,225	0	9,225	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	183,164	6,745	189,909	0 192.00
192.01 19201	ASC MOB	0	0	0	0	0 192.01
192.02 19202	EDUCATION CENTER	0	0	0	0	0 192.02
192.03 19203	MARKETING	0	0	0	0	0 192.03
194.00 07950	FOUNDATION	0	1,614	91	1,705	0 194.00
194.01 07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0 194.01
194.02 07952	CLINIC OF HOPE	0	0	601	601	970 194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	2,364,684	2,971,292	2,280,102	7,616,078	115,694 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 3:55 pm			
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	2,850,969				5.00
7.00	00700	OPERATION OF PLANT	218,611	845,819			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,477	1,969	21,090		8.00
9.00	00900	HOUSEKEEPING	48,232	7,660	6,555	85,981	9.00
10.00	01000	DIETARY	28,975	19,786	0	0	106,346
11.00	01100	CAFETERIA	29,477	23,986	0	0	0
13.00	01300	NURSING ADMINISTRATION	57,466	20,759	0	66	0
15.00	01500	PHARMACY	533,653	12,160	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	54,139	9,302	0	22	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	ALLIED HEALTH-RAD TECH	14,980	3,406	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	253,109	111,925	6,819	27,561	73,150
31.00	03100	INTENSIVE CARE UNIT	52,300	21,424	1,666	6,584	8,985
41.00	04100	SUBPROVIDER - I&R	43,504	51,576	664	6,584	14,532
43.00	04300	NURSERY	20,383	6,116	279	3,647	9,679
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	222,105	124,106	214	13,167	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,754	12,407	756	6,315	0
53.00	05300	ANESTHESIOLOGY	1,283	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,675	98,153	472	1,339	0
54.01	03630	ULTRA SOUND	12,868	0	87	285	0
56.00	05600	RADIOISOTOPE	28,662	0	0	988	0
57.00	05700	CT SCAN	11,724	0	170	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,094	0	41	0	0
59.00	05900	CARDIAC CATHETERIZATION	6,616	1,521	0	439	0
60.00	06000	LABORATORY	158,575	30,030	16	2,721	0
65.00	06500	RESPIRATORY THERAPY	54,793	4,702	14	132	0
66.00	06600	PHYSICAL THERAPY	95,996	27,426	0	318	0
67.00	06700	OCCUPATIONAL THERAPY	35,760	11,769	0	149	0
68.00	06800	SPEECH PATHOLOGY	5,622	3,953	13	302	0
69.00	06900	ELECTROCARDIOLOGY	29,171	15,217	0	176	0
70.00	07000	ELECTROENCEPHALOGRAPHY	18,794	10,370	0	1,119	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,029	16,380	476	2,458	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,765	0	1	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2	988	0
74.00	07400	RENAL DIALYSIS	6,339	0	0	439	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	47,098	17,452	0	878	0
76.01	03190	CHEMOTHERAPY	140,549	0	0	0	0
76.02	03330	ENDOSCOPY	11,538	0	0	0	0
76.03	03950	WOUND CARE CENTER	28,418	11,404	0	1,404	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	84,335	73,517	2,566	7,900	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	35,900	15,083	279	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,750,769	763,559	21,090	85,981	106,346
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	267	3,912	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,519	77,664	0	0	0
192.01	19201	ASC MOB	1,064	0	0	0	0
192.02	19202	EDUCATION CENTER	534	0	0	0	0
192.03	19203	MARKETING	45,938	0	0	0	0
194.00	07950	FOUNDATION	66	684	0	0	0
194.01	07951	ASPR BIOTERRORISM GRANT	333	0	0	0	0
194.02	07952	CLINIC OF HOPE	14,479	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,850,969	845,819	21,090	85,981	106,346

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 3:55 pm		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS
		11.00	13.00	15.00	16.00	22.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	127,157				11.00
13.00	01300	2,572	318,436			13.00
15.00	01500	4,241	0	584,324		15.00
16.00	01600	4,229	0	0	100,121	16.00
22.00	02200	0	0	0	0	0 22.00
23.00	02300	1,652	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	29,613	123,992	0	6,001	30.00
31.00	03100	5,656	23,683	0	1,469	31.00
41.00	04100	5,121	21,441	0	1,012	41.00
43.00	04300	1,524	6,380	0	595	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	15,371	64,360	0	14,834	50.00
52.00	05200	4,611	19,309	0	2,569	52.00
53.00	05300	0	0	0	1,752	53.00
54.00	05400	5,351	0	0	3,542	54.00
54.01	03630	987	0	0	2,417	54.01
56.00	05600	0	0	0	3,304	56.00
57.00	05700	1,197	0	0	2,098	57.00
58.00	05800	1,166	0	0	575	58.00
59.00	05900	241	1,010	0	490	59.00
60.00	06000	0	0	0	13,052	60.00
65.00	06500	5,121	0	0	2,560	65.00
66.00	06600	8,787	0	0	2,782	66.00
67.00	06700	2,902	0	0	917	67.00
68.00	06800	444	0	0	140	68.00
69.00	06900	3,617	0	0	2,780	69.00
70.00	07000	1,470	0	0	1,184	70.00
71.00	07100	1,759	0	0	2,944	71.00
72.00	07200	0	0	0	2,653	72.00
73.00	07300	0	0	583,075	9,498	73.00
74.00	07400	0	0	0	39	74.00
76.00	03550	5,611	0	0	1,046	76.00
76.01	03190	4,051	16,964	0	2,228	76.01
76.02	03330	661	2,769	0	923	76.02
76.03	03950	1,264	5,291	0	3,121	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	7,938	33,237	0	11,936	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	0	1,660	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
115.00	11500	0	0	0	0	115.00
118.00		127,157	318,436	583,075	100,121	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	0	0	0	192.02
192.03	19203	0	0	0	0	192.03
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	1,249	0	194.02
200.00						0 200.00
201.00		0	0	0	0	0 201.00
202.00		127,157	318,436	584,324	100,121	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 3:55 pm	
Cost Center	Description	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	ALLIED HEALTH-RAD TECH	29,167			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,067,177	0	1,067,177	30.00
31.00	03100	INTENSIVE CARE UNIT	185,594	0	185,594	31.00
41.00	04100	SUBPROVIDER - I RF	271,007	0	271,007	41.00
43.00	04300	NURSERY	81,780	0	81,780	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,020,505	0	1,020,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,820	0	177,820	52.00
53.00	05300	ANESTHESIOLOGY	36,683	0	36,683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,110,893	0	1,110,893	54.00
54.01	03630	ULTRA SOUND	21,520	0	21,520	54.01
56.00	05600	RADIOISOTOPE	60,331	0	60,331	56.00
57.00	05700	CT SCAN	17,832	0	17,832	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,701	0	13,701	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,673	0	16,673	59.00
60.00	06000	LABORATORY	279,196	0	279,196	60.00
65.00	06500	RESPIRATORY THERAPY	82,095	0	82,095	65.00
66.00	06600	PHYSICAL THERAPY	296,559	0	296,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,146	0	111,146	67.00
68.00	06800	SPEECH PATHOLOGY	24,680	0	24,680	68.00
69.00	06900	ELECTROCARDIOLOGY	170,688	0	170,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	116,428	0	116,428	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	237,085	0	237,085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,419	0	101,419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	593,563	0	593,563	73.00
74.00	07400	RENAL DIALYSIS	6,817	0	6,817	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	117,052	0	117,052	76.00
76.01	03190	CHEMOTHERAPY	175,523	0	175,523	76.01
76.02	03330	ENDOSCOPY	55,374	0	55,374	76.02
76.03	03950	WOUND CARE CENTER	85,717	0	85,717	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	445,715	0	445,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	220,219	0	220,219	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,200,792	7,200,792	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,404	0	13,404	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	305,092	0	305,092	192.00
192.01	19201	ASC MOB	1,064	0	1,064	192.01
192.02	19202	EDUCATION CENTER	534	0	534	192.02
192.03	19203	MARKETING	45,938	0	45,938	192.03
194.00	07950	FOUNDATION	2,455	0	2,455	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	333	0	333	194.01
194.02	07952	CLINIC OF HOPE	17,299	0	17,299	194.02
200.00		Cross Foot Adjustments	29,167	0	29,167	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,167	7,616,078	7,616,078	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	331,432				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,987,369			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	665	41,099,850		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	50,113	12,304	8,138,290	-25,550,454	98,318,721
7.00 00700	OPERATION OF PLANT	45,990	186,578	300,777	0	7,539,105
8.00 00800	LAUNDRY & LINEN SERVICE	518	0	0	0	499,262
9.00 00900	HOUSEKEEPING	2,015	4,768	0	0	1,663,360
10.00 01000	DIETARY	5,205	9,520	0	0	999,240
11.00 01100	CAFETERIA	6,310	14,926	0	0	1,016,546
13.00 01300	NURSING ADMINISTRATION	5,461	161,386	1,227,988	0	1,981,796
15.00 01500	PHARMACY	3,199	401	1,822,877	0	18,402,886
16.00 01600	MEDICAL RECORDS & LIBRARY	2,447	6,642	1,020,099	0	1,867,065
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	ALLIED HEALTH-RAD TECH	896	0	389,190	0	516,611
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	29,444	133,870	6,199,659	0	8,728,815
31.00 03100	INTENSIVE CARE UNIT	5,636	8,301	1,341,230	0	1,803,648
41.00 04100	SUBPROVIDER - IRF	13,568	1,743	1,042,881	0	1,500,296
43.00 04300	NURSERY	1,609	15,193	469,365	0	702,918
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,649	229,727	3,582,408	0	7,659,590
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,264	41,188	1,272,470	0	1,784,819
53.00 05300	ANESTHESIOLOGY	0	29,328	0	0	44,252
54.00 05400	RADIOLOGY-DIAGNOSTIC	25,821	582,398	1,311,701	0	3,402,938
54.01 03630	ULTRA SOUND	0	3,428	335,052	0	443,777
56.00 05600	RADIO SOTOPE	0	22,878	400,910	0	988,431
57.00 05700	CT SCAN	0	1,553	305,967	0	404,302
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	293,011	0	382,582
59.00 05900	CARDIAC CATHETERIZATION	400	2,182	94,836	0	228,151
60.00 06000	LABORATORY	7,900	3,467	0	0	5,468,668
65.00 06500	RESPIRATORY THERAPY	1,237	0	1,308,509	0	1,889,614
66.00 06600	PHYSICAL THERAPY	7,215	78,605	2,267,930	0	3,310,550
67.00 06700	OCCUPATIONAL THERAPY	3,096	25,961	748,895	0	1,233,237
68.00 06800	SPEECH PATHOLOGY	1,040	3,974	114,653	0	193,873
69.00 06900	ELECTROCARDIOLOGY	4,003	71,480	650,573	0	1,005,992
70.00 07000	ELECTROENCEPHALOGRAPHY	2,728	50,576	357,956	0	648,141
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	76,584	548,531	0	2,932,355
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,406,033
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	218,622
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	1,353,188	0	1,624,242
76.01 03190	CHEMOTHERAPY	0	8,633	648,498	0	4,847,005
76.02 03330	ENDOSCOPY	0	33,989	173,357	0	397,890
76.03 03950	WOUND CARE CENTER	3,000	6,249	266,885	0	980,022
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	19,340	39,447	2,005,540	0	2,908,410
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,968	112,943	762,037	0	1,238,042
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	309,792	1,980,887	40,755,263	-25,550,454	94,863,086
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	9,225
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	20,431	5,879	0	0	1,293,906
192.01 19201	ASC MOB	0	0	0	0	36,708
192.02 19202	EDUCATION CENTER	0	0	0	0	18,429
192.03 19203	MARKETING	0	0	0	0	1,584,250
194.00 07950	FOUNDATION	180	79	0	0	2,289
194.01 07951	ASPR BIOTERRORISM GRANT	0	0	0	0	11,486
194.02 07952	CLINIC OF HOPE	0	524	344,587	0	499,342
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,971,292	2,280,102	9,082,602		25,550,454

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	8.965012	1.147297	0.220989		0.259874	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			115,694		2,850,969	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002815		0.028997	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)		
		7.00	8.00	9.00	10.00	11.00		
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	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	222,509				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	518	773,612			8.00	
9.00	00900	HOUSEKEEPING	2,015	240,455	195,900		9.00	
10.00	01000	DIETARY	5,205	0	0	24,040	10.00	
11.00	01100	CAFETERIA	6,310	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	5,461	0	150	0	13.00	
15.00	01500	PHARMACY	3,199	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	50	0	16.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00	
23.00	02300	ALLIED HEALTH-RAD TECH	896	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,444	250,092	62,801	16,536	254,873	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	61,113	15,000	2,031	48,683	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	24,355	15,000	3,285	44,074	41.00
43.00	04300	NURSERY	1,609	10,228	8,310	2,188	13,114	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,649	7,834	30,000	0	132,298	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	27,728	14,389	0	39,691	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,821	17,322	3,050	0	46,059	54.00
54.01	03630	ULTRA SOUND	0	3,185	650	0	8,491	54.01
56.00	05600	RADIOISOTOPE	0	0	2,250	0	0	56.00
57.00	05700	CT SCAN	0	6,240	0	0	10,300	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,505	0	0	10,033	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	0	1,000	0	2,077	59.00
60.00	06000	LABORATORY	7,900	577	6,200	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	531	300	0	44,074	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	724	0	75,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	339	0	24,979	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	490	687	0	3,824	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	400	0	31,133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,550	0	12,655	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	17,470	5,600	0	15,144	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	85	2,250	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	2,000	0	48,296	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	34,870	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	5,691	76.02
76.03	03950	WOUND CARE CENTER	3,000	0	3,200	0	10,877	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,340	94,130	18,000	0	68,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,968	10,217	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,869	773,612	195,900	24,040	1,094,449	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	FOUNDATION	180	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	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)	9,498,322	651,119	2,384,021	1,481,104	1,550,077	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.687361	0.841661	12.169581	61.609983	1.416308	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	845,819	21,090	85,981	106,346	127,157	204.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0010			Period: From 07/01/2016 To 06/30/2017		Worksheet B-1 Date/Time Prepared: 11/28/2017 3:55 pm	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)		
		7.00	8.00	9.00	10.00	11.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	3.801280	0.027262	0.438903	4.423710	0.116184	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	ALLIED HEALTH-RAD TECH (RADIOLOGY CHARGES)	
	13.00	15.00	16.00	22.00	23.00	
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
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION	654,570					13.00
15.00 01500 PHARMACY	0	4,127,271				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	508,337,434			16.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00 02300 ALLIED HEALTH-RAD TECH	0	0	0		60,587,153	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	254,873	0	30,463,263	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	48,683	0	7,456,142	0	0	31.00
41.00 04100 SUBPROVIDER - IRF	44,074	0	5,137,299	0	0	41.00
43.00 04300 NURSERY	13,114	0	3,018,188	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	132,298	0	75,417,180	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	39,691	0	13,040,916	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	8,890,962	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	17,978,182	0	17,978,182	54.00
54.01 03630 ULTRA SOUND	0	0	12,268,204	0	12,268,204	54.01
56.00 05600 RADIOISOTOPE	0	0	16,773,431	0	16,773,431	56.00
57.00 05700 CT SCAN	0	0	10,648,582	0	10,648,582	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	2,918,754	0	2,918,754	58.00
59.00 05900 CARDIAC CATHETERIZATION	2,077	0	2,487,102	0	0	59.00
60.00 06000 LABORATORY	0	0	66,251,972	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	12,993,463	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	14,120,402	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	4,654,362	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	712,564	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	14,111,355	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	6,010,003	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	14,943,533	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	13,468,537	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,118,451	48,215,717	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	196,028	0	0	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	5,308,538	0	0	76.00
76.01 03190 CHEMOTHERAPY	34,870	0	11,310,533	0	0	76.01
76.02 03330 ENDOSCOPY	5,691	0	4,683,548	0	0	76.02
76.03 03950 WOUND CARE CENTER	10,877	0	15,844,024	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	68,322	0	60,587,909	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	8,426,741	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	654,570	4,118,451	508,337,434	0	60,587,153	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 ASC MOB	0	0	0	0	0	192.01
192.02 19202 EDUCATION CENTER	0	0	0	0	0	192.02
192.03 19203 MARKETING	0	0	0	0	0	192.03
194.00 07950 FOUNDATION	0	0	0	0	0	194.00
194.01 07951 ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02 07952 CLINIC OF HOPE	0	8,820	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)	2,763,111	23,373,547	2,508,886	0	709,247

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		NURSING ADMINISTRATION	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	ALLIED HEALTH-RAD TECH (RADIOLOGY CHARGES)	
		(DIRECT NURS. HRS.)					
		13.00	15.00	16.00	22.00	23.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	4.221261	5.663197	0.004935	0.000000	0.011706	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	318,436	584,324	100,121	0	29,167	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.486481	0.141576	0.000197	0.000000	0.000481	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 3:55 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		15,834,827	56,190	15,891,017
31.00	03100 INTENSIVE CARE UNIT		3,183,315	0	3,183,315
41.00	04100 SUBPROVIDER - I RF		3,148,621	0	3,148,621
43.00	04300 NURSERY		1,287,639	0	1,287,639
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		12,533,762	0	12,533,762
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,874,543	0	2,874,543
53.00	05300 ANESTHESIOLOGY		99,629	0	99,629
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,805,621	0	5,805,621
54.01	03630 ULTRA SOUND		785,876	0	785,876
56.00	05600 RADIO SOTOPE		1,551,808	0	1,551,808
57.00	05700 CT SCAN		706,413	0	706,413
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		546,053	0	546,053
59.00	05900 CARDIAC CATHETERIZATION		340,671	0	340,671
60.00	06000 LABORATORY		7,629,953	0	7,629,953
65.00	06500 RESPIRATORY THERAPY	0	2,564,123	0	2,564,123
66.00	06600 PHYSICAL THERAPY	0	4,664,481	0	4,664,481
67.00	06700 OCCUPATIONAL THERAPY	0	1,748,355	0	1,748,355
68.00	06800 SPEECH PATHOLOGY	0	306,357	0	306,357
69.00	06900 ELECTROCARDIOLOGY		1,556,903	0	1,556,903
70.00	07000 ELECTROENCEPHALOGRAPHY		1,011,641	0	1,011,641
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,056,387	0	4,056,387
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		4,357,685	0	4,357,685
73.00	07300 DRUGS CHARGED TO PATIENTS		23,588,997	0	23,588,997
74.00	07400 RENAL DIALYSIS		288,573	0	288,573
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		2,361,257	2,241	2,363,498
76.01	03190 CHEMOTHERAPY		6,359,015	0	6,359,015
76.02	03330 ENDOSCOPY		556,487	0	556,487
76.03	03950 WOUND CARE CENTER		1,541,219	0	1,541,219
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		0	0	0
91.00	09100 EMERGENCY		5,472,252	0	5,472,252
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		924,971	0	924,971
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		1,779,345	0	1,779,345
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE		0	0	0
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0
200.00	Subtotal (see instructions)		119,466,779	58,431	119,525,210
201.00	Less Observation Beds		924,971	0	924,971
202.00	Total (see instructions)		118,541,808	58,431	118,600,239

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/28/2017 3:55 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	28,767,115		28,767,115				30.00
31.00	03100	INTENSIVE CARE UNIT	7,456,142		7,456,142				31.00
41.00	04100	SUBPROVIDER - IRF	5,137,299		5,137,299				41.00
43.00	04300	NURSERY	3,018,188		3,018,188				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	28,077,450	47,339,730	75,417,180	0.166192	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,789,563	1,251,353	13,040,916	0.220425	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	3,208,680	5,682,282	8,890,962	0.011206	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,975,695	15,002,487	17,978,182	0.322926	0.000000		54.00
54.01	03630	ULTRA SOUND	1,210,232	11,057,972	12,268,204	0.064058	0.000000		54.01
56.00	05600	RADIOISOTOPE	409,154	16,364,277	16,773,431	0.092516	0.000000		56.00
57.00	05700	CT SCAN	2,164,596	8,483,986	10,648,582	0.066339	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	509,775	2,408,979	2,918,754	0.187084	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	558,029	1,929,073	2,487,102	0.136975	0.000000		59.00
60.00	06000	LABORATORY	24,638,070	41,613,902	66,251,972	0.115166	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	9,276,250	3,717,213	12,993,463	0.197339	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	3,874,269	10,246,133	14,120,402	0.330336	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,934,782	1,719,580	4,654,362	0.375638	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	414,770	297,794	712,564	0.429936	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,295,310	11,816,045	14,111,355	0.110330	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	176,855	5,833,148	6,010,003	0.168326	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,870,626	7,072,907	14,943,533	0.271448	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,691,994	2,776,543	13,468,537	0.323546	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,870,116	40,345,601	48,215,717	0.489239	0.000000		73.00
74.00	07400	RENAL DIALYSIS	185,975	10,053	196,028	1.472101	0.000000		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,267	5,274,271	5,308,538	0.444804	0.000000		76.00
76.01	03190	CHEMOTHERAPY	153,713	11,156,820	11,310,533	0.562221	0.000000		76.01
76.02	03330	ENDOSCOPY	384,603	4,298,945	4,683,548	0.118817	0.000000		76.02
76.03	03950	WOUND CARE CENTER	208,625	15,635,399	15,844,024	0.097274	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	10,448,037	50,139,872	60,587,909	0.090319	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,696,148	1,696,148	0.545336	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	10,002	8,416,739	8,426,741	0.211155	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
200.00		Subtotal (see instructions)	176,750,182	331,587,252	508,337,434				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	176,750,182	331,587,252	508,337,434				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166192	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220425	52.00
53.00	05300	ANESTHESIOLOGY	0.011206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.322926	54.00
54.01	03630	ULTRA SOUND	0.064058	54.01
56.00	05600	RADIOISOTOPE	0.092516	56.00
57.00	05700	CT SCAN	0.066339	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.187084	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.136975	59.00
60.00	06000	LABORATORY	0.115166	60.00
65.00	06500	RESPIRATORY THERAPY	0.197339	65.00
66.00	06600	PHYSICAL THERAPY	0.330336	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.375638	67.00
68.00	06800	SPEECH PATHOLOGY	0.429936	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110330	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.168326	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.323546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489239	73.00
74.00	07400	RENAL DIALYSIS	1.472101	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.445226	76.00
76.01	03190	CHEMOTHERAPY	0.562221	76.01
76.02	03330	ENDOSCOPY	0.118817	76.02
76.03	03950	WOUND CARE CENTER	0.097274	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.090319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.211155	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 3:55 pm	
			Title XIX	Hospital	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		15,834,827	56,190	15,891,017	30.00
31.00	03100 INTENSIVE CARE UNIT		3,183,315	0	3,183,315	31.00
41.00	04100 SUBPROVIDER - I RF		3,148,621	0	3,148,621	41.00
43.00	04300 NURSERY		1,287,639	0	1,287,639	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		12,533,762	0	12,533,762	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,874,543	0	2,874,543	52.00
53.00	05300 ANESTHESIOLOGY		99,629	0	99,629	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,805,621	0	5,805,621	54.00
54.01	03630 ULTRA SOUND		785,876	0	785,876	54.01
56.00	05600 RADIO SOTOPE		1,551,808	0	1,551,808	56.00
57.00	05700 CT SCAN		706,413	0	706,413	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		546,053	0	546,053	58.00
59.00	05900 CARDIAC CATHETERIZATION		340,671	0	340,671	59.00
60.00	06000 LABORATORY		7,629,953	0	7,629,953	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,564,123	0	2,564,123	65.00
66.00	06600 PHYSICAL THERAPY	0	4,664,481	0	4,664,481	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,748,355	0	1,748,355	67.00
68.00	06800 SPEECH PATHOLOGY	0	306,357	0	306,357	68.00
69.00	06900 ELECTROCARDIOLOGY		1,556,903	0	1,556,903	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,011,641	0	1,011,641	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,056,387	0	4,056,387	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		4,357,685	0	4,357,685	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		23,588,997	0	23,588,997	73.00
74.00	07400 RENAL DIALYSIS		288,573	0	288,573	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		2,361,257	2,241	2,363,498	76.00
76.01	03190 CHEMOTHERAPY		6,359,015	0	6,359,015	76.01
76.02	03330 ENDOSCOPY		556,487	0	556,487	76.02
76.03	03950 WOUND CARE CENTER		1,541,219	0	1,541,219	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY		5,472,252	0	5,472,252	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		924,971	0	924,971	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,779,345	0	1,779,345	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
200.00	Subtotal (see instructions)		119,466,779	58,431	119,525,210	200.00
201.00	Less Observation Beds		924,971	0	924,971	201.00
202.00	Total (see instructions)		118,541,808	58,431	118,600,239	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/28/2017 3:55 pm		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	28,767,115		28,767,115				30.00
31.00	03100	INTENSIVE CARE UNIT	7,456,142		7,456,142				31.00
41.00	04100	SUBPROVIDER - IRF	5,137,299		5,137,299				41.00
43.00	04300	NURSERY	3,018,188		3,018,188				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	28,077,450	47,339,730	75,417,180	0.166192	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,789,563	1,251,353	13,040,916	0.220425	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	3,208,680	5,682,282	8,890,962	0.011206	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,975,695	15,002,487	17,978,182	0.322926	0.000000		54.00
54.01	03630	ULTRA SOUND	1,210,232	11,057,972	12,268,204	0.064058	0.000000		54.01
56.00	05600	RADIOISOTOPE	409,154	16,364,277	16,773,431	0.092516	0.000000		56.00
57.00	05700	CT SCAN	2,164,596	8,483,986	10,648,582	0.066339	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	509,775	2,408,979	2,918,754	0.187084	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	558,029	1,929,073	2,487,102	0.136975	0.000000		59.00
60.00	06000	LABORATORY	24,638,070	41,613,902	66,251,972	0.115166	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	9,276,250	3,717,213	12,993,463	0.197339	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	3,874,269	10,246,133	14,120,402	0.330336	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,934,782	1,719,580	4,654,362	0.375638	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	414,770	297,794	712,564	0.429936	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,295,310	11,816,045	14,111,355	0.110330	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	176,855	5,833,148	6,010,003	0.168326	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,870,626	7,072,907	14,943,533	0.271448	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,691,994	2,776,543	13,468,537	0.323546	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,870,116	40,345,601	48,215,717	0.489239	0.000000		73.00
74.00	07400	RENAL DIALYSIS	185,975	10,053	196,028	1.472101	0.000000		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,267	5,274,271	5,308,538	0.444804	0.000000		76.00
76.01	03190	CHEMOTHERAPY	153,713	11,156,820	11,310,533	0.562221	0.000000		76.01
76.02	03330	ENDOSCOPY	384,603	4,298,945	4,683,548	0.118817	0.000000		76.02
76.03	03950	WOUND CARE CENTER	208,625	15,635,399	15,844,024	0.097274	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	10,448,037	50,139,872	60,587,909	0.090319	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,696,148	1,696,148	0.545336	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	10,002	8,416,739	8,426,741	0.211155	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
200.00		Subtotal (see instructions)	176,750,182	331,587,252	508,337,434				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	176,750,182	331,587,252	508,337,434				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 3:55 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03190 CHEMOTHERAPY	0.000000		76.01
76.02	03330 ENDOSCOPY	0.000000		76.02
76.03	03950 WOUND CARE CENTER	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part I Date/Time Prepared: 11/28/2017 3:55 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,067,177	0	1,067,177	17,558	60.78	30.00
31.00	INTENSIVE CARE UNIT	185,594	0	185,594	2,031	91.38	31.00
41.00	SUBPROVIDER - IRF	271,007	0	271,007	3,285	82.50	41.00
43.00	NURSERY	81,780		81,780	2,188	37.38	43.00
200.00	Total (lines 30-199)	1,605,558		1,605,558	25,062		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,337	445,943				
31.00	INTENSIVE CARE UNIT	1,127	102,985				
41.00	SUBPROVIDER - IRF	2,430	200,475				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	10,894	749,403				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/28/2017 3:55 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,020,505	75,417,180	0.013531	14,303,104	193,535	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	177,820	13,040,916	0.013636	25,720	351	52.00
53.00	05300 ANESTHESIOLOGY	36,683	8,890,962	0.004126	1,571,286	6,483	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,110,893	17,978,182	0.061791	1,667,984	103,066	54.00
54.01	03630 ULTRA SOUND	21,520	12,268,204	0.001754	552,808	970	54.01
56.00	05600 RADIOISOTOPE	60,331	16,773,431	0.003597	215,972	777	56.00
57.00	05700 CT SCAN	17,832	10,648,582	0.001675	1,224,000	2,050	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13,701	2,918,754	0.004694	273,600	1,284	58.00
59.00	05900 CARDIAC CATHETERIZATION	16,673	2,487,102	0.006704	237,144	1,590	59.00
60.00	06000 LABORATORY	279,196	66,251,972	0.004214	11,725,698	49,412	60.00
65.00	06500 RESPIRATORY THERAPY	82,095	12,993,463	0.006318	4,498,155	28,419	65.00
66.00	06600 PHYSICAL THERAPY	296,559	14,120,402	0.021002	1,438,094	30,203	66.00
67.00	06700 OCCUPATIONAL THERAPY	111,146	4,654,362	0.023880	994,253	23,743	67.00
68.00	06800 SPEECH PATHOLOGY	24,680	712,564	0.034635	198,057	6,860	68.00
69.00	06900 ELECTROCARDIOLOGY	170,688	14,111,355	0.012096	1,876,279	22,695	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	116,428	6,010,003	0.019372	111,579	2,162	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	237,085	14,943,533	0.015865	4,114,161	65,271	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	101,419	13,468,537	0.007530	6,079,280	45,777	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	593,563	48,215,717	0.012311	3,990,563	49,128	73.00
74.00	07400 RENAL DIALYSIS	6,817	196,028	0.034776	103,540	3,601	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	117,052	5,308,538	0.022050	0	0	76.00
76.01	03190 CHEMOTHERAPY	175,523	11,310,533	0.015519	12,974	201	76.01
76.02	03330 ENDOSCOPY	55,374	4,683,548	0.011823	247,112	2,922	76.02
76.03	03950 WOUND CARE CENTER	85,717	15,844,024	0.005410	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	445,715	60,587,909	0.007357	6,048,970	44,502	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	62,117	1,696,148	0.036622	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	5,437,132	455,531,949		61,510,333	685,002	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/28/2017 3:55 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,558	0.00	7,337	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,031	0.00	1,127	0		31.00
41.00	04100	SUBPROVIDER - IRF	3,285	0.00	2,430	0		41.00
43.00	04300	NURSERY	2,188	0.00	0	0		43.00
200.00		Total (lines 30-199)	25,062		10,894	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part IV
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	210,466	0	210,466	54.00
54.01	03630	ULTRASOUND	0	0	143,612	0	143,612	54.01
56.00	05600	RADIOISOTOPE	0	0	196,350	0	196,350	56.00
57.00	05700	CT SCAN	0	0	124,652	0	124,652	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	34,167	0	34,167	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	709,247	0	709,247	95.00
200.00		Total (Lines 50-199)	0	0	709,247	0	709,247	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:55 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	75,417,180	0.000000	0.000000	14,303,104	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	13,040,916	0.000000	0.000000	25,720	52.00
53.00	05300 ANESTHESIOLOGY	0	8,890,962	0.000000	0.000000	1,571,286	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	210,466	17,978,182	0.011707	0.011707	1,667,984	54.00
54.01	03630 ULTRA SOUND	143,612	12,268,204	0.011706	0.011706	552,808	54.01
56.00	05600 RADIOISOTOPE	196,350	16,773,431	0.011706	0.011706	215,972	56.00
57.00	05700 CT SCAN	124,652	10,648,582	0.011706	0.011706	1,224,000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	34,167	2,918,754	0.011706	0.011706	273,600	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,487,102	0.000000	0.000000	237,144	59.00
60.00	06000 LABORATORY	0	66,251,972	0.000000	0.000000	11,725,698	60.00
65.00	06500 RESPIRATORY THERAPY	0	12,993,463	0.000000	0.000000	4,498,155	65.00
66.00	06600 PHYSICAL THERAPY	0	14,120,402	0.000000	0.000000	1,438,094	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	4,654,362	0.000000	0.000000	994,253	67.00
68.00	06800 SPEECH PATHOLOGY	0	712,564	0.000000	0.000000	198,057	68.00
69.00	06900 ELECTROCARDIOLOGY	0	14,111,355	0.000000	0.000000	1,876,279	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	6,010,003	0.000000	0.000000	111,579	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,943,533	0.000000	0.000000	4,114,161	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,468,537	0.000000	0.000000	6,079,280	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	48,215,717	0.000000	0.000000	3,990,563	73.00
74.00	07400 RENAL DIALYSIS	0	196,028	0.000000	0.000000	103,540	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,308,538	0.000000	0.000000	0	76.00
76.01	03190 CHEMOTHERAPY	0	11,310,533	0.000000	0.000000	12,974	76.01
76.02	03330 ENDOSCOPY	0	4,683,548	0.000000	0.000000	247,112	76.02
76.03	03950 WOUND CARE CENTER	0	15,844,024	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	60,587,909	0.000000	0.000000	6,048,970	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,696,148	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	709,247	455,531,949			61,510,333	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:55 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	16,909,895	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	11,164	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,830,582	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	19,527	9,104,253	106,583	54.00
54.01	03630 ULTRA SOUND	6,471	2,042,564	23,910	54.01
56.00	05600 RADIOISOTOPE	2,528	5,862,860	68,631	56.00
57.00	05700 CT SCAN	14,328	3,204,500	37,512	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,203	912,192	10,678	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	7,748,841	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,669,373	0	65.00
66.00	06600 PHYSICAL THERAPY	0	30,039	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	24,074	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	15,028	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	6,638,025	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,515,347	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,501,975	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,117,642	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	20,881,209	0	73.00
74.00	07400 RENAL DIALYSIS	0	3,131	0	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
76.01	03190 CHEMOTHERAPY	0	1,461,383	0	76.01
76.02	03330 ENDOSCOPY	0	1,157,336	0	76.02
76.03	03950 WOUND CARE CENTER	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	14,960,270	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	8,481,991	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	46,057	108,083,674	247,314	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.166192	16,909,895	0	0	2,810,289	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.220425	11,164	0	0	2,461	52.00
53.00	05300 ANESTHESIOLOGY	0.011206	1,830,582	0	0	20,514	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	9,104,253	0	0	2,940,000	54.00
54.01	03630 ULTRA SOUND	0.064058	2,042,564	0	0	130,843	54.01
56.00	05600 RADIOISOTOPE	0.092516	5,862,860	0	0	542,408	56.00
57.00	05700 CT SCAN	0.066339	3,204,500	0	0	212,583	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.187084	912,192	0	0	170,657	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.136975	0	0	0	0	59.00
60.00	06000 LABORATORY	0.115166	7,748,841	0	0	892,403	60.00
65.00	06500 RESPIRATORY THERAPY	0.197339	1,669,373	0	0	329,432	65.00
66.00	06600 PHYSICAL THERAPY	0.330336	30,039	0	0	9,923	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.375638	24,074	0	0	9,043	67.00
68.00	06800 SPEECH PATHOLOGY	0.429936	15,028	0	0	6,461	68.00
69.00	06900 ELECTROCARDIOLOGY	0.110330	6,638,025	0	0	732,373	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.168326	1,515,347	0	0	255,072	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	2,501,975	0	0	679,156	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.323546	1,117,642	0	0	361,609	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489239	20,881,209	0	10,822	10,215,902	73.00
74.00	07400 RENAL DIALYSIS	1.472101	3,131	0	0	4,609	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444804	0	0	0	0	76.00
76.01	03190 CHEMOTHERAPY	0.562221	1,461,383	0	0	821,620	76.01
76.02	03330 ENDOSCOPY	0.118817	1,157,336	0	0	137,511	76.02
76.03	03950 WOUND CARE CENTER	0.097274	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.090319	14,960,270	0	0	1,351,197	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	8,481,991	0	0	4,625,535	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.211155		0			95.00
200.00	Subtotal (see instructions)		108,083,674	0	10,822	27,261,601	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		108,083,674	0	10,822	27,261,601	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 3:55 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,295		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01 03190 CHEMOTHERAPY	0	0		76.01
76.02 03330 ENDOSCOPY	0	0		76.02
76.03 03950 WOUND CARE CENTER	0	0		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	5,295		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,295		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0010 Component CCN: 15-T010		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part II Date/Time Prepared: 11/28/2017 3:55 pm	
Title XVIII				Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,020,505	75,417,180	0.013531	29,664	401	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	177,820	13,040,916	0.013636	0	0	52.00
53.00	05300 ANESTHESIOLOGY	36,683	8,890,962	0.004126	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,110,893	17,978,182	0.061791	58,222	3,598	54.00
54.01	03630 ULTRA SOUND	21,520	12,268,204	0.001754	20,764	36	54.01
56.00	05600 RADIOISOTOPE	60,331	16,773,431	0.003597	4,773	17	56.00
57.00	05700 CT SCAN	17,832	10,648,582	0.001675	22,100	37	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13,701	2,918,754	0.004694	6,650	31	58.00
59.00	05900 CARDIAC CATHETERIZATION	16,673	2,487,102	0.006704	0	0	59.00
60.00	06000 LABORATORY	279,196	66,251,972	0.004214	1,105,707	4,659	60.00
65.00	06500 RESPIRATORY THERAPY	82,095	12,993,463	0.006318	446,027	2,818	65.00
66.00	06600 PHYSICAL THERAPY	296,559	14,120,402	0.021002	1,242,648	26,098	66.00
67.00	06700 OCCUPATIONAL THERAPY	111,146	4,654,362	0.023880	1,075,109	25,674	67.00
68.00	06800 SPEECH PATHOLOGY	24,680	712,564	0.034635	102,957	3,566	68.00
69.00	06900 ELECTROCARDIOLOGY	170,688	14,111,355	0.012096	12,159	147	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	116,428	6,010,003	0.019372	982	19	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	237,085	14,943,533	0.015865	190,141	3,017	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	101,419	13,468,537	0.007530	11,874	89	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	593,563	48,215,717	0.012311	421,235	5,186	73.00
74.00	07400 RENAL DIALYSIS	6,817	196,028	0.034776	40,372	1,404	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	117,052	5,308,538	0.022050	0	0	76.00
76.01	03190 CHEMOTHERAPY	175,523	11,310,533	0.015519	0	0	76.01
76.02	03330 ENDOSCOPY	55,374	4,683,548	0.011823	0	0	76.02
76.03	03950 WOUND CARE CENTER	85,717	15,844,024	0.005410	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	445,715	60,587,909	0.007357	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,696,148	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	5,375,015	455,531,949		4,791,384	76,797	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:55 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	210,466	0	210,466	54.00
54.01	03630 ULTRA SOUND	0	0	143,612	0	143,612	54.01
56.00	05600 RADIOISOTOPE	0	0	196,350	0	196,350	56.00
57.00	05700 CT SCAN	0	0	124,652	0	124,652	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	34,167	0	34,167	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190 CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330 ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950 WOUND CARE CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	709,247	0	709,247	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:55 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	75,417,180	0.000000	0.000000	29,664	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	13,040,916	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	8,890,962	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	210,466	17,978,182	0.011707	0.011707	58,222	54.00
54.01	03630 ULTRA SOUND	143,612	12,268,204	0.011706	0.011706	20,764	54.01
56.00	05600 RADIOISOTOPE	196,350	16,773,431	0.011706	0.011706	4,773	56.00
57.00	05700 CT SCAN	124,652	10,648,582	0.011706	0.011706	22,100	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	34,167	2,918,754	0.011706	0.011706	6,650	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,487,102	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	66,251,972	0.000000	0.000000	1,105,707	60.00
65.00	06500 RESPIRATORY THERAPY	0	12,993,463	0.000000	0.000000	446,027	65.00
66.00	06600 PHYSICAL THERAPY	0	14,120,402	0.000000	0.000000	1,242,648	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	4,654,362	0.000000	0.000000	1,075,109	67.00
68.00	06800 SPEECH PATHOLOGY	0	712,564	0.000000	0.000000	102,957	68.00
69.00	06900 ELECTROCARDIOLOGY	0	14,111,355	0.000000	0.000000	12,159	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	6,010,003	0.000000	0.000000	982	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,943,533	0.000000	0.000000	190,141	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,468,537	0.000000	0.000000	11,874	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	48,215,717	0.000000	0.000000	421,235	73.00
74.00	07400 RENAL DIALYSIS	0	196,028	0.000000	0.000000	40,372	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	5,308,538	0.000000	0.000000	0	76.00
76.01	03190 CHEMOTHERAPY	0	11,310,533	0.000000	0.000000	0	76.01
76.02	03330 ENDOSCOPY	0	4,683,548	0.000000	0.000000	0	76.02
76.03	03950 WOUND CARE CENTER	0	15,844,024	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	60,587,909	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,696,148	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	709,247	455,531,949			4,791,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:55 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	682	392	5	54.00
54.01	03630 ULTRA SOUND	243	0	0	54.01
56.00	05600 RADIOISOTOPE	56	0	0	56.00
57.00	05700 CT SCAN	259	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	78	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	142	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	53	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
76.01	03190 CHEMOTHERAPY	0	0	0	76.01
76.02	03330 ENDOSCOPY	0	0	0	76.02
76.03	03950 WOUND CARE CENTER	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	1,318	587	5	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 3:55 pm
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.166192	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.220425	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.011206	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.322926	392	0	0	127	54.00
54.01 03630 ULTRA SOUND	0.064058	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.092516	0	0	0	0	56.00
57.00 05700 CT SCAN	0.066339	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.187084	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.136975	0	0	0	0	59.00
60.00 06000 LABORATORY	0.115166	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.197339	142	0	0	28	65.00
66.00 06600 PHYSICAL THERAPY	0.330336	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.375638	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.429936	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.110330	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.168326	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	53	0	0	14	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.323546	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.489239	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	1.472101	0	0	0	0	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444804	0	0	0	0	76.00
76.01 03190 CHEMOTHERAPY	0.562221	0	0	0	0	76.01
76.02 03330 ENDOSCOPY	0.118817	0	0	0	0	76.02
76.03 03950 WOUND CARE CENTER	0.097274	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.090319	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.211155		0	0		95.00
200.00	Subtotal (see instructions)		587	0	169	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		587	0	169	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 3:55 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03630 ULTRA SOUND	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01 03190 CHEMOTHERAPY	0	0	76.01
76.02 03330 ENDOSCOPY	0	0	76.02
76.03 03950 WOUND CARE CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 09500 AMBULANCE SERVICES	0	0	95.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 3:55 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.166192	4,310,589	0	0	716,385	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.220425	606,913	0	0	133,779	52.00
53.00	05300	ANESTHESIOLOGY	0.011206	561,367	0	0	6,291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.322926	1,939,911	0	0	626,448	54.00
54.01	03630	ULTRA SOUND	0.064058	1,182,398	0	0	75,742	54.01
56.00	05600	RADIOISOTOPE	0.092516	741,176	0	0	68,571	56.00
57.00	05700	CT SCAN	0.066339	1,222,958	0	0	81,130	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.187084	253,954	0	0	47,511	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.136975	67,350	0	0	9,225	59.00
60.00	06000	LABORATORY	0.115166	7,514,228	0	0	865,384	60.00
65.00	06500	RESPIRATORY THERAPY	0.197339	543,342	0	0	107,223	65.00
66.00	06600	PHYSICAL THERAPY	0.330336	1,093,831	0	0	361,332	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.375638	183,177	0	0	68,808	67.00
68.00	06800	SPEECH PATHOLOGY	0.429936	31,402	0	0	13,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110330	658,423	0	0	72,644	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.168326	837,618	0	0	140,993	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	526,320	0	0	142,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.323546	206,716	0	0	66,882	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489239	3,561,106	0	0	1,742,232	73.00
74.00	07400	RENAL DIALYSIS	1.472101	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444804	1,840,837	0	0	818,812	76.00
76.01	03190	CHEMOTHERAPY	0.562221	725,992	0	0	408,168	76.01
76.02	03330	ENDOSCOPY	0.118817	325,610	0	0	38,688	76.02
76.03	03950	WOUND CARE CENTER	0.097274	2,456,751	0	0	238,978	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.090319	14,245,707	0	0	1,286,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	402,995	0	0	219,768	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.211155	2,007,860	0	0	0	95.00
200.00		Subtotal (see instructions)		46,040,671	0	0	8,781,992	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		46,040,671	0	0	8,781,992	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 3:55 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01	03190 CHEMOTHERAPY	0	0	76.01
76.02	03330 ENDOSCOPY	0	0	76.02
76.03	03950 WOUND CARE CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,558	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)		16,536	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)		7,337	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)		15,891,017	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)		15,891,017	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)		15,891,017	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)		905.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,640,425	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)		6,640,425	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm	
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)	PPS
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,183,315	2,031	1,567.36	1,127	1,766,415	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)					12,328,234	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					20,735,074	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)					548,928	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					731,059	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,279,987	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					19,455,087	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,022	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					905.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					924,971	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,067,177	15,891,017	0.067156	924,971	62,117	90.00
91.00	Nursing School cost	0	15,891,017	0.000000	924,971	0	91.00
92.00	Allied health cost	0	15,891,017	0.000000	924,971	0	92.00
93.00	All other Medical Education	0	15,891,017	0.000000	924,971	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,285	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,285	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)		3,285	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)		2,430	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)		3,148,621	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)		3,148,621	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)		3,148,621	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)		958.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,329,106	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)		2,329,106	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1	
				Component CCN: 15-T010	Date/Time Prepared: 11/28/2017 3:55 pm		
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,424,659	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						3,753,765	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)						200,475	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						78,115	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						278,590	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						3,475,175	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: 15-0010 Component CCN: 15-T010		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	271,007	3,148,621	0.086072	0	0	90.00
91.00	Nursing School cost	0	3,148,621	0.000000	0	0	91.00
92.00	Allied health cost	0	3,148,621	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,148,621	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,558	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)		16,536	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)		233	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)		2,188	15.00
16.00	Nursery days (title V or XIX only)		251	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)		15,834,827	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)		15,834,827	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)		15,834,827	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)		901.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		210,133	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)		210,133	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm	
Cost Center Description			Title XIX		Hospital		Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
42.00	NURSERY (title V & XIX only)	1,287,639	2,188	588.50	251	147,714		42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	3,183,315	2,031	1,567.36	82	128,524		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,013,222		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,499,593		49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							0 54.00
55.00	Target amount per discharge					0.00		55.00
56.00	Target amount (line 54 x line 55)							0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0 57.00
58.00	Bonus payment (see instructions)							0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0 61.00
62.00	Relief payment (see instructions)							0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)					1,022		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					901.86		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					921,701		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 3:55 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,067,177	15,834,827	0.067394	921,701	62,117	90.00
91.00	Nursing School cost	0	15,834,827	0.000000	921,701	0	91.00
92.00	Allied health cost	0	15,834,827	0.000000	921,701	0	92.00
93.00	All other Medical Education	0	15,834,827	0.000000	921,701	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 3:55 pm	
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		12,009,499		30.00
31.00	03100 INTENSIVE CARE UNIT		4,071,291		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.166192	14,303,104	2,377,061	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.220425	25,720	5,669	52.00
53.00	05300 ANESTHESIOLOGY	0.011206	1,571,286	17,608	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	1,667,984	538,635	54.00
54.01	03630 ULTRA SOUND	0.064058	552,808	35,412	54.01
56.00	05600 RADIOISOTOPE	0.092516	215,972	19,981	56.00
57.00	05700 CT SCAN	0.066339	1,224,000	81,199	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.187084	273,600	51,186	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.136975	237,144	32,483	59.00
60.00	06000 LABORATORY	0.115166	11,725,698	1,350,402	60.00
65.00	06500 RESPIRATORY THERAPY	0.197339	4,498,155	887,661	65.00
66.00	06600 PHYSICAL THERAPY	0.330336	1,438,094	475,054	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.375638	994,253	373,479	67.00
68.00	06800 SPEECH PATHOLOGY	0.429936	198,057	85,152	68.00
69.00	06900 ELECTROCARDIOLOGY	0.110330	1,876,279	207,010	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.168326	111,579	18,782	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	4,114,161	1,116,781	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.323546	6,079,280	1,966,927	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489239	3,990,563	1,952,339	73.00
74.00	07400 RENAL DIALYSIS	1.472101	103,540	152,421	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.445226	0	0	76.00
76.01	03190 CHEMOTHERAPY	0.562221	12,974	7,294	76.01
76.02	03330 ENDOSCOPY	0.118817	247,112	29,361	76.02
76.03	03950 WOUND CARE CENTER	0.097274	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.090319	6,048,970	546,337	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		61,510,333	12,328,234	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)		61,510,333		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 3:55 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		3,804,861		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.166192	29,664	4,930	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.220425	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.011206	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	58,222	18,801	54.00
54.01	03630 ULTRA SOUND	0.064058	20,764	1,330	54.01
56.00	05600 RADIOISOTOPE	0.092516	4,773	442	56.00
57.00	05700 CT SCAN	0.066339	22,100	1,466	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.187084	6,650	1,244	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.136975	0	0	59.00
60.00	06000 LABORATORY	0.115166	1,105,707	127,340	60.00
65.00	06500 RESPIRATORY THERAPY	0.197339	446,027	88,019	65.00
66.00	06600 PHYSICAL THERAPY	0.330336	1,242,648	410,491	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.375638	1,075,109	403,852	67.00
68.00	06800 SPEECH PATHOLOGY	0.429936	102,957	44,265	68.00
69.00	06900 ELECTROCARDIOLOGY	0.110330	12,159	1,342	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.168326	982	165	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	190,141	51,613	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.323546	11,874	3,842	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489239	421,235	206,085	73.00
74.00	07400 RENAL DIALYSIS	1.472101	40,372	59,432	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.445226	0	0	76.00
76.01	03190 CHEMOTHERAPY	0.562221	0	0	76.01
76.02	03330 ENDOSCOPY	0.118817	0	0	76.02
76.03	03950 WOUND CARE CENTER	0.097274	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.090319	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,791,384	1,424,659	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)		4,791,384		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 3:55 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		5,102,628		30.00
31.00	03100 INTENSIVE CARE UNIT		1,024,211		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		861,687		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.166192	2,419,024	402,022	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.220425	7,425,540	1,636,775	52.00
53.00	05300 ANESTHESIOLOGY	0.011206	451,782	5,063	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	276,981	89,444	54.00
54.01	03630 ULTRA SOUND	0.064058	131,114	8,399	54.01
56.00	05600 RADIOISOTOPE	0.092516	90,584	8,380	56.00
57.00	05700 CT SCAN	0.066339	219,233	14,544	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.187084	61,343	11,476	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.136975	86,395	11,834	59.00
60.00	06000 LABORATORY	0.115166	4,416,756	508,660	60.00
65.00	06500 RESPIRATORY THERAPY	0.197339	936,684	184,844	65.00
66.00	06600 PHYSICAL THERAPY	0.330336	111,051	36,684	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.375638	126,679	47,585	67.00
68.00	06800 SPEECH PATHOLOGY	0.429936	17,903	7,697	68.00
69.00	06900 ELECTROCARDIOLOGY	0.110330	251,215	27,717	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.168326	19,243	3,239	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	433,386	117,642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.323546	588,741	190,485	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489239	1,128,541	552,126	73.00
74.00	07400 RENAL DIALYSIS	1.472101	3,670	5,403	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444804	22,744	10,117	76.00
76.01	03190 CHEMOTHERAPY	0.562221	0	0	76.01
76.02	03330 ENDOSCOPY	0.118817	41,281	4,905	76.02
76.03	03950 WOUND CARE CENTER	0.097274	26,549	2,583	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.090319	1,390,600	125,598	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		20,677,039	4,013,222	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)		20,677,039		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 3:55 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		118,854		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.166192	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.220425	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.011206	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.322926	876	283	54.00
54.01	03630 ULTRA SOUND	0.064058	0	0	54.01
56.00	05600 RADIOISOTOPE	0.092516	0	0	56.00
57.00	05700 CT SCAN	0.066339	1,700	113	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.187084	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.136975	0	0	59.00
60.00	06000 LABORATORY	0.115166	20,791	2,394	60.00
65.00	06500 RESPIRATORY THERAPY	0.197339	12,563	2,479	65.00
66.00	06600 PHYSICAL THERAPY	0.330336	40,686	13,440	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.375638	13,437	5,047	67.00
68.00	06800 SPEECH PATHOLOGY	0.429936	2,057	884	68.00
69.00	06900 ELECTROCARDIOLOGY	0.110330	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.168326	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.271448	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.323546	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489239	9,253	4,527	73.00
74.00	07400 RENAL DIALYSIS	1.472101	0	0	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444804	0	0	76.00
76.01	03190 CHEMOTHERAPY	0.562221	0	0	76.01
76.02	03330 ENDOSCOPY	0.118817	0	0	76.02
76.03	03950 WOUND CARE CENTER	0.097274	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.090319	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.545336	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		101,363	29,167	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)		101,363		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,900,413	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		12,005,686	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		478,325	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		104.20	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.51	31.00
32.00	Sum of lines 30 and 31		27.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.10	33.00
34.00	Disproportionate share adjustment (see instructions)		481,160	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000160247	0.000142294	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,026,564	850,562	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	258,043	636,174	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	894,217		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	17,759,801		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		17,759,801	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,377,657	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		46,057	58.00
59.00	Total (sum of amounts on lines 49 through 58)		19,183,515	59.00
60.00	Primary payer payments		31,856	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		19,151,659	61.00
62.00	Deductibles billed to program beneficiaries		1,908,536	62.00
63.00	Coinurance billed to program beneficiaries		25,095	63.00
64.00	Allowable bad debts (see instructions)		172,138	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		111,890	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,610	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,329,918	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-31,692	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 3:55 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			17,298,226	71.00
71.01	Sequestration adjustment (see instructions)			345,965	71.01
72.00	Interim payments			16,895,540	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			56,721	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			117,847	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2017 3:55 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,900,413	0	3,900,413		3,900,413	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,005,686	0		12,005,686	12,005,686	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	478,325	0	165,440	312,885	478,325	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1210	0.1210	0.1210	0.1210		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	481,160	0	117,988	363,172	481,160	11.00
11.01	Uncompensated care payments	36.00	894,217	0	258,043	636,174	894,217	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,759,801	0	4,441,884	13,317,917	17,759,801	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,759,801	0	4,441,884	13,317,917	17,759,801	15.00
16.00	Payment for inpatient program capital	50.00	1,377,657	0	338,867	1,038,790	1,377,657	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2017 3:55 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
19.00	SUBTOTAL		0	4,780,751	14,356,707	19,137,458	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,275,833	0	310,433	965,400	1,275,833	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,953	0	10,460	17,493	27,953	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0579	0.0579	0.0579	0.0579		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,871	0	17,974	55,897	73,871	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,377,657	0	338,867	1,038,790	1,377,657	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0010		Period: From 07/01/2016 To 06/30/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2017 3:55 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,900,413	3,900,413		3,900,413	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,005,686		12,005,686	12,005,686	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	478,325	165,440	312,885	478,325	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1210	0.1210	0.1210		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	481,160	117,988	363,172	481,160	11.00
11.01	Uncompensated care payments	36.00	894,217	258,043	636,174	894,217	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,759,801	4,441,884	13,317,917	17,759,801	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,759,801	4,441,884	13,317,917	17,759,801	15.00
16.00	Payment for inpatient program capital	50.00	1,377,657	338,867	1,038,790	1,377,657	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,780,751	14,356,707	19,137,458	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2017 3:55 pm

		Title XVIII				Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)						
		0	1.00	2.00	3.00	4.00			
20.00	Capital DRG other than outlier	1.00	1,275,833	310,433	965,400	1,275,833	20.00		
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01		
21.00	Capital DRG outlier payments	2.00	27,953	10,460	17,493	27,953	21.00		
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01		
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00		
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00		
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0579	0.0579	0.0579		24.00		
25.00	Disproportionate share adjustment (see instructions)	11.00	73,871	17,974	55,897	73,871	25.00		
26.00	Total prospective capital payments (see instructions)	12.00	1,377,657	338,867	1,038,790	1,377,657	26.00		
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)						
		0	1.00	2.00	3.00	4.00			
27.00							27.00		
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00		
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00		
30.00	HVBP payment adjustment (see instructions)	70.93	-31,692	8,065	-39,757	-31,692	30.00		
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01		
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00		
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01		
						(Amt. to Wkst. E, Pt. A)			
		0	1.00	2.00	3.00	4.00			
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00		
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00		

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,295	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		27,014,287	2.00
3.00	PPS payments		19,468,957	3.00
4.00	Outlier payment (see instructions)		161,669	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.228	5.00
6.00	Line 2 times line 5		6,159,257	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		247,314	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,295	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,822	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		10,822	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		10,822	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,527	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,295	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		19,877,940	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,827,246	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		16,055,989	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		16,055,989	30.00
31.00	Primary payer payments		609	31.00
32.00	Subtotal (line 30 minus line 31)		16,055,380	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		268,243	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		174,358	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		145,758	36.00
37.00	Subtotal (see instructions)		16,229,738	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		16,229,738	40.00
40.01	Sequestration adjustment (see instructions)		324,595	40.01
41.00	Interim payments		16,019,790	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-114,647	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			164 2.00
3.00	PPS payments			57 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			5 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			62 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			11 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			51 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			51 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			51 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			51 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			51 40.00
40.01	Sequestration adjustment (see instructions)			1 40.01
41.00	Interim payments			44 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			6 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2017 3:55 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		16,895,540		15,966,690	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	12/27/2016	53,100	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		53,100	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)		16,895,540		16,019,790	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		56,721		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		114,647	6.02	
7.00	Total Medicare program liability (see instructions)		16,952,261		15,905,143	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0010
Component CCN: 15-T010

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2017 3:55 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		3,608,846		44	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)		3,608,846		44	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		6	6.01
6.02	SETTLEMENT TO PROGRAM		16,724		0	6.02
7.00	Total Medicare program liability (see instructions)		3,592,122		50	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		5,113	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		8,464	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		1,610	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		18,567	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		508,337,434	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		13,318,267	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		389,037	8.00
9.00	Sequestration adjustment amount (see instructions)		7,781	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		381,256	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		415,538	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		-34,282	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part III Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,606,501 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0123 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			60,229 3.00
4.00	Outlier Payments			48,383 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)			9.000000 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)			3,715,113 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,715,113 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,715,113 19.00
20.00	Deductibles			46,872 20.00
21.00	Subtotal (line 19 minus line 20)			3,668,241 21.00
22.00	Coinsurance			10,948 22.00
23.00	Subtotal (line 21 minus line 22)			3,657,293 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			10,493 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			6,820 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,288 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,664,113 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)			1,318 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	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,665,431 32.00
32.01	Sequestration adjustment (see instructions)			73,309 32.01
33.00	Interim payments			3,608,846 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, 33, and 34)			-16,724 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			16,949 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			48,383 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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet G
Date/Time Prepared:
11/28/2017 3:55 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	1,520	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	47,445,845	0	0	0	4.00
5.00	Other receivable	1,124,766	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,498,415	0	0	0	6.00
7.00	Inventory	1,808,105	0	0	0	7.00
8.00	Prepaid expenses	115,179	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	2,372,400	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,369,400	0	0	0	11.00
FIXED ASSETS						
12.00	Land	722,779	0	0	0	12.00
13.00	Land improvements	1,764,978	0	0	0	13.00
14.00	Accumulated depreciation	-1,421,048	0	0	0	14.00
15.00	Buildings	62,802,504	0	0	0	15.00
16.00	Accumulated depreciation	-51,628,651	0	0	0	16.00
17.00	Leasehold improvements	528,071	0	0	0	17.00
18.00	Accumulated depreciation	-526,196	0	0	0	18.00
19.00	Fixed equipment	24,344,356	0	0	0	19.00
20.00	Accumulated depreciation	-20,485,795	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	38,971,186	0	0	0	23.00
24.00	Accumulated depreciation	-32,914,129	0	0	0	24.00
25.00	Minor equipment depreciable	566,610	0	0	0	25.00
26.00	Accumulated depreciation	-405,249	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	2,887,958	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,207,374	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	83,561	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	83,561	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,660,335	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,522,567	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,667,620	0	0	0	38.00
39.00	Payroll taxes payable	403,587	0	0	0	39.00
40.00	Notes and loans payable (short term)	211,608	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	11,387,887	0	0	0	43.00
44.00	Other current liabilities	2,385,082	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,578,351	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,695,926	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,937,907	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,633,833	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	45,212,184	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,448,151				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)	5,448,151	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,660,335	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-1

Date/Time Prepared:
11/28/2017 3:55 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		151,433,914		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		28,297,492			2.00
3.00	Total (sum of line 1 and line 2)		179,731,406		0	3.00
4.00	TRANSFER OF TEMPORARY RESTRICTIONS	175,068		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		175,068		0	10.00
11.00	Subtotal (line 3 plus line 10)		179,906,474		0	11.00
12.00	TRANSFERS FROM/TO AFFILIATES	174,458,324		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		174,458,324		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,448,150		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	TRANSFER OF TEMPORARY RESTRICTIONS		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	TRANSFERS FROM/TO AFFILIATES		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: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2017 3:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,276,802		14,276,802	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,137,299		5,137,299	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)	19,414,101		19,414,101	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,319,468		1,319,468	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,319,468		1,319,468	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,733,569		20,733,569	17.00
18.00	Ancillary services	156,016,613		156,016,613	18.00
19.00	Outpatient services	0	331,587,251	331,587,251	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN SERVICES	0	83,259	83,259	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	176,750,182	331,670,510	508,420,692	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		132,695,340		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		132,695,340		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0010

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-3

Date/Time Prepared:
11/28/2017 3:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	508,420,692	1.00
2.00	Less contractual allowances and discounts on patients' accounts	349,337,350	2.00
3.00	Net patient revenues (line 1 minus line 2)	159,083,342	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	132,695,340	4.00
5.00	Net income from service to patients (line 3 minus line 4)	26,388,002	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	12,000	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	597,367	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	17,262	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	179,493	22.00
23.00	Governmental appropriations	515,247	23.00
24.00	OTHER MISCELLANEOUS REVENUE	268,201	24.00
24.01	GRANT REVENUE	108,272	24.01
24.02	MEALS ON WHEELS	20,462	24.02
24.03	INTERCOMPANY SPACE RENTAL	164,836	24.03
24.04	ASSETS RELEASED FROM RESTRICTED FUND	26,350	24.04
25.00	Total other income (sum of lines 6-24)	1,909,490	25.00
26.00	Total (line 5 plus line 25)	28,297,492	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)	28,297,492	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0010	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/28/2017 3:55 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,275,833	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		27,953	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		52.66	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.29	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.51	8.00
9.00	Sum of lines 7 and 8		27.80	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.79	10.00
11.00	Disproportionate share adjustment (see instructions)		73,871	11.00
12.00	Total prospective capital payments (see instructions)		1,377,657	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00