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: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 1:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2018 Time: 1:50 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL CLINTON (15-1326) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	662,790	822,081	0	15,737	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	26,370	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	689,160	822,081	0	15,737	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: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2018 1:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: CLINTON	State: IN	Zip Code: 47842-	County: VERMILLION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BEDS	15Z326	45460		03/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 1:49 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 1:49 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 1:49 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 1:49 pm

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	118,169	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2018 1:49 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H043	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: UNION HOSPITAL, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:		142.00
143.00	City: TERRE HAUTE	State: IN	Zip Code: 47804	143.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 1:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 1:49 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/19/2018	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.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/04/2018	Y	04/04/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 1:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	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.	CAROLYN	CHAPLIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919	CCHAPLIN@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 1:49 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2018 1:49 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,935	37,440.00	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)		19	6,935	37,440.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	6,792.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	44,232.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2018 1:49 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	918	19	1,560			1.00
2.00	HMO and other (see instructions)	83	130				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	97	0	98			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,015	19	1,658			7.00
8.00	INTENSIVE CARE UNIT	156	0	283			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)	1,171	19	1,941	0.00	124.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	124.62	27.00
28.00	Observation Bed Days		0	571			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2018 1:49 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	424	6	678	1.00
2.00	HMO and other (see instructions)			24	35		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	424	6	678	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/30/2018 1:49 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.334221	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,069,435	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	17,088,571	6.00
7.00	Medicaid cost (line 1 times line 6)	5,711,359	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)	4,641,924	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)	4,641,924	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,766,077	0	1,766,077	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	590,260	0	590,260	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	590,260	0	590,260	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,312,910	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	484,250	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	745,000	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,567,910	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,118,999	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,709,259	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,351,183	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		741,879	741,879	-36,859	705,020	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		287,686	287,686	-1,576	286,110	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	43,445	43,445	0	43,445	5.01
5.02	00550	DATA PROCESSING	0	776,135	776,135	0	776,135	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	68,636	68,636	0	68,636	5.03
5.04	00570	ADMITTING	388,235	128,127	516,362	0	516,362	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,622	287,364	308,986	0	308,986	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	677,077	1,410,534	2,087,611	0	2,087,611	5.06
7.00	00700	OPERATION OF PLANT	366,491	707,077	1,073,568	0	1,073,568	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	588	588	0	588	8.00
9.00	00900	HOUSEKEEPING	218,706	84,701	303,407	0	303,407	9.00
10.00	01000	DIETARY	315,419	233,599	549,018	-445,879	103,139	10.00
11.00	01100	CAFETERIA	0	0	0	445,879	445,879	11.00
13.00	01300	NURSING ADMINISTRATION	525,794	93,555	619,349	0	619,349	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	185,453	104,744	290,197	0	290,197	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,006,588	536,692	1,543,280	0	1,543,280	30.00
31.00	03100	INTENSIVE CARE UNIT	689,928	133,364	823,292	0	823,292	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	355,989	388,079	744,068	20,900	764,968	50.00
51.00	05100	RECOVERY ROOM	40,759	3,304	44,063	0	44,063	51.00
51.01	05101	O/P TREATMENT ROOM	160,224	40,833	201,057	0	201,057	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	658,867	763,263	1,422,130	30	1,422,160	54.00
56.00	05600	RADIOISOTOPE	0	98,853	98,853	0	98,853	56.00
60.00	06000	LABORATORY	0	832,541	832,541	0	832,541	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	30,973	30,973	0	30,973	62.00
65.00	06500	RESPIRATORY THERAPY	413,277	115,081	528,358	4,880	533,238	65.00
66.00	06600	PHYSICAL THERAPY	0	1,344,339	1,344,339	0	1,344,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,986	7,986	0	7,986	67.00
68.00	06800	SPEECH PATHOLOGY	0	45,526	45,526	0	45,526	68.00
69.00	06900	ELECTROCARDIOLOGY	98,491	111,330	209,821	0	209,821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,272	65,272	-57,584	7,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	405,845	811,015	1,216,860	3,749	1,220,609	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,196,356	2,085,542	3,281,898	28,025	3,309,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,725,121	12,382,063	20,107,184	-38,435	20,068,749	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	47,199	103,523	150,722	0	150,722	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	38,435	38,435	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	7,772,320	12,485,586	20,257,906	0	20,257,906	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	642,713	1,347,733	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	286,110	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,643,172	2,643,172	4.00
5.01	00540	NONPATIENT TELEPHONES	30,958	74,403	5.01
5.02	00550	DATA PROCESSING	2,157,424	2,933,559	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	112,794	181,430	5.03
5.04	00570	ADMITTING	0	516,362	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	322,847	631,833	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	-308,399	1,779,212	5.06
7.00	00700	OPERATION OF PLANT	117,534	1,191,102	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	588	8.00
9.00	00900	HOUSEKEEPING	22,931	326,338	9.00
10.00	01000	DIETARY	3,947	107,086	10.00
11.00	01100	CAFETERIA	-157,056	288,823	11.00
13.00	01300	NURSING ADMINISTRATION	83,353	702,702	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,783	301,980	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-460,792	1,082,488	30.00
31.00	03100	INTENSIVE CARE UNIT	0	823,292	31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-35,338	729,630	50.00
51.00	05100	RECOVERY ROOM	103	44,166	51.00
51.01	05101	O/P TREATMENT ROOM	0	201,057	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,921	1,424,081	54.00
56.00	05600	RADIOISOTOPE	0	98,853	56.00
60.00	06000	LABORATORY	0	832,541	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	30,973	62.00
65.00	06500	RESPIRATORY THERAPY	0	533,238	65.00
66.00	06600	PHYSICAL THERAPY	-792,329	552,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,905	140,891	67.00
68.00	06800	SPEECH PATHOLOGY	-15,457	30,069	68.00
69.00	06900	ELECTROCARDIOLOGY	7,823	217,644	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,371	1,255,980	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	3,309,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,558,208	24,626,957	118.00
	NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	150,722	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	38,435	194.01
194.02	07952	VPCHC	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	4,558,208	24,816,114	200.00

RECLASSIFICATIONS

Provider CCN: 15-1326

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

Worksheet A-6

Date/Time Prepared: 5/30/2018 1:49 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	256,164	189,715	1.00
	0		256,164	189,715	
	B - DEPRECIATION RECLASS				
1.00	MEDICAL OFFICE BUILDING	194.01	0	38,435	1.00
2.00		0.00	0	0	2.00
	0		0	38,435	
	C - CENTRAL SUPPLIES RECLASS				
1.00	OPERATING ROOM	50.00	0	20,900	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30	2.00
3.00	RESPIRATORY THERAPY	65.00	0	4,880	3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,143	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,749	5.00
6.00	EMERGENCY	91.00	0	28,025	6.00
	TOTALS		0	68,727	
500.00	Grand Total: Increases		256,164	296,877	500.00

RECLASSIFICATIONS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 1:49 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	256,164	189,715	0		1.00
	0		256,164	189,715			
	B - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36,859	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,576	9		2.00
	0		0	38,435			
	C - CENTRAL SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	68,727	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	68,727			
500.00	Grand Total: Decreases		256,164	296,877			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I Date/Time Prepared: 5/30/2018 1:49 pm

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	339,822	0	0	0	0	1.00
2.00	Land Improvements	269,938	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,545,480	233,668	0	233,668	0	3.00
4.00	Building Improvements	1,645,471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,777,868	1,079,437	0	1,079,437	18,213	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,578,579	1,313,105	0	1,313,105	18,213	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,578,579	1,313,105	0	1,313,105	18,213	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	339,822	0	1.00
2.00	Land Improvements	269,938	0	2.00
3.00	Buildings and Fixtures	11,779,148	0	3.00
4.00	Building Improvements	1,645,471	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,839,092	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,873,471	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,873,471	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2018 1:49 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	741,080	0	799	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	287,686	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,028,766	0	799	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	NEW CAP REL COSTS-BLDG & FIXT	0	741,879	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	287,686	2.00
3.00	Total (sum of lines 1-2)	0	1,029,565	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2018 1:49 pm

	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	NEW CAP REL COSTS-BLDG & FIXT	14,034,379	0	14,034,379	0.672355	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,839,092	0	6,839,092	0.327645	0	2.00
3.00	Total (sum of lines 1-2)	20,873,471	0	20,873,471	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,347,733	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	286,110	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,633,843	0	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 cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,347,733	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	286,110	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,633,843	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 1:49 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	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-799	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-583,194			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	6,601,613			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 1:49 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-12,366	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	MISCELLANEOUS REVENUE	B	-23,761	ADMINISTRATIVE AND GENERAL	5.06	0	33.00
33.01	CAFETERIA REVENUE	B	-176,104	CAFETERIA	11.00	0	33.01
33.02	CATERING REVENUE	B	-2,228	CAFETERIA	11.00	0	33.02
35.00	ADVERTISING	A	-1,172	ADMINISTRATIVE AND GENERAL	5.06	0	35.00
36.00	VPCHC	B	-7,226	HOUSEKEEPING	9.00	0	36.00
39.00	RENTAL REVENUE	B	-150,979	OPERATION OF PLANT	7.00	0	39.00
42.00	HAF	A	-1,055,576	ADMINISTRATIVE AND GENERAL	5.06	0	42.00
43.00	PHYSICIAN RECRUITMENT	A	-30,000	ADMINISTRATIVE AND GENERAL	5.06	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		4,558,208				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: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/30/2018 1:49 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	655,878	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,643,172	0	2.00
3.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	30,958	0	3.00
4.00	5.02	DATA PROCESSING	HOME OFFICE	2,157,424	0	4.00
4.01	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	112,794	0	4.01
4.02	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	322,847	0	4.02
4.03	5.06	ADMINISTRATIVE AND GENERAL	HOME OFFICE	802,110	0	4.03
4.04	7.00	OPERATION OF PLANT	HOME OFFICE	268,513	0	4.04
4.05	9.00	HOUSEKEEPING	HOME OFFICE	30,157	0	4.05
4.06	10.00	DIETARY	HOME OFFICE	3,947	0	4.06
4.07	11.00	CAFETERIA	HOME OFFICE	21,276	0	4.07
4.08	13.00	NURSING ADMINISTRATION	HOME OFFICE	83,353	0	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	11,783	0	4.09
4.10	50.00	OPERATING ROOM	HOME OFFICE	2,812	0	4.10
4.11	51.00	RECOVERY ROOM	HOME OFFICE	103	0	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	86,055	0	4.12
4.13	66.00	PHYSICAL THERAPY	HOME OFFICE	5,415	0	4.13
4.14	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	1,610	0	4.14
4.15	68.00	SPEECH PATHOLOGY	HOME OFFICE	323	0	4.15
4.16	69.00	ELECTROCARDIOLOGY	HOME OFFICE	7,941	0	4.16
4.17	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	35,371	0	4.17
4.18	66.00	PHYSICAL THERAPY	THERAPY	441,523	1,239,267	4.18
4.19	67.00	OCCUPATIONAL THERAPY	THERAPY	131,295	0	4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	26,331	42,111	4.20
5.00	0		0	7,882,991	1,281,378	5.00

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

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

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

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

6.00	G		0.00	UNION HOSPITAL	100.00	6.00
7.00	G		0.00	UNION THERAPY	51.00	7.00
8.00			0.00		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:	OTHER				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: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/30/2018 1:49 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	655,878	9	1.00
2.00	2,643,172	0	2.00
3.00	30,958	0	3.00
4.00	2,157,424	0	4.00
4.01	112,794	0	4.01
4.02	322,847	0	4.02
4.03	802,110	0	4.03
4.04	268,513	0	4.04
4.05	30,157	0	4.05
4.06	3,947	0	4.06
4.07	21,276	0	4.07
4.08	83,353	0	4.08
4.09	11,783	0	4.09
4.10	2,812	0	4.10
4.11	103	0	4.11
4.12	86,055	0	4.12
4.13	5,415	0	4.13
4.14	1,610	0	4.14
4.15	323	0	4.15
4.16	7,941	0	4.16
4.17	35,371	0	4.17
4.18	-797,744	0	4.18
4.19	131,295	0	4.19
4.20	-15,780	0	4.20
5.00	6,601,613		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	HOME OFFICE	6.00
7.00	THERAPY	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: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2018 1:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	460,792	460,792	0	0	0	1.00
2.00	50.00	OPERATING ROOM	38,150	38,150	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	84,134	84,134	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	118	118	0	0	0	4.00
5.00	91.00	EMERGENCY	1,788,456	0	1,788,456	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,371,650	583,194	1,788,456		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	460,792	1.00
2.00	50.00	OPERATING ROOM	0	0	0	38,150	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	84,134	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	118	4.00
5.00	91.00	EMERGENCY	0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	583,194	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,347,733	1,347,733				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	286,110		286,110			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,643,172	0	0	2,643,172		4.00
5.01	00540	NONPATIENT TELEPHONES	74,403	1,802	20,075	0	96,280	5.01
5.02	00550	DATA PROCESSING	2,933,559	3,517	0	0	741	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	181,430	13,704	87,321	0	1,111	5.03
5.04	00570	ADMITTING	516,362	8,731	702	132,029	2,222	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	631,833	5,163	0	7,353	1,481	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,779,212	25,536	8,516	230,257	5,555	5.06
7.00	00700	OPERATION OF PLANT	1,191,102	372,231	7,148	124,634	7,776	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	588	7,172	395	0	0	8.00
9.00	00900	HOUSEKEEPING	326,338	6,791	3,551	74,376	370	9.00
10.00	01000	DIETARY	107,086	16,233	1,911	20,151	370	10.00
11.00	01100	CAFETERIA	288,823	61,103	8,146	87,115	2,222	11.00
13.00	01300	NURSING ADMINISTRATION	702,702	23,942	302	178,809	1,481	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301,980	15,159	177	63,068	3,333	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,082,488	242,333	21,781	342,315	27,033	30.00
31.00	03100	INTENSIVE CARE UNIT	823,292	7,103	32,371	234,627	2,222	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	729,630	51,713	31,947	121,063	2,592	50.00
51.00	05100	RECOVERY ROOM	44,166	5,215	1,749	13,861	741	51.00
51.01	05101	O/P TREATMENT ROOM	201,057	27,858	2,430	54,488	4,073	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,424,081	98,836	28,238	224,064	4,814	54.00
56.00	05600	RADIOISOTOPE	98,853	4,556	0	0	370	56.00
60.00	06000	LABORATORY	832,541	29,642	0	0	1,852	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,973	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	533,238	17,740	10,622	140,545	2,592	65.00
66.00	06600	PHYSICAL THERAPY	552,010	58,539	1,492	0	4,073	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,891	49,236	0	0	2,962	67.00
68.00	06800	SPEECH PATHOLOGY	30,069	6,653	0	0	741	68.00
69.00	06900	ELECTROCARDIOLOGY	217,644	7,259	471	33,494	1,852	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,688	17,602	0	0	370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,255,980	17,567	1,065	138,018	2,222	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,309,923	144,797	15,700	406,854	11,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,626,957	1,347,733	286,110	2,627,121	96,280	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	150,722	0	0	16,051	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	38,435	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,816,114	1,347,733	286,110	2,643,172	96,280	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	2,937,817					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	283,566				5.03
5.04	00570	ADMITTING	135,592	484	796,122			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	45,197	0	0	691,027		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	293,782	182	0	0	2,343,040	5.06
7.00	00700	OPERATION OF PLANT	587,562	38	0	0	2,290,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	186	0	0	8,341	8.00
9.00	00900	HOUSEKEEPING	22,599	22,846	0	0	456,871	9.00
10.00	01000	DIETARY	22,599	15	0	0	168,365	10.00
11.00	01100	CAFETERIA	45,197	65	0	0	492,671	11.00
13.00	01300	NURSING ADMINISTRATION	90,394	5	0	0	997,635	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	180,789	13	0	0	564,519	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	248,585	35,972	226,088	34,245	2,260,840	30.00
31.00	03100	INTENSIVE CARE UNIT	22,599	23,503	52,409	8,762	1,206,888	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	90,394	76,526	99,565	49,512	1,252,942	50.00
51.00	05100	RECOVERY ROOM	0	0	3,107	1,801	70,640	51.00
51.01	05101	O/P TREATMENT ROOM	22,599	17,858	628	9,029	340,020	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,387	23,593	80,676	186,363	2,274,052	54.00
56.00	05600	RADIOISOTOPE	0	239	1,801	4,878	110,697	56.00
60.00	06000	LABORATORY	22,599	0	87,704	82,829	1,057,167	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	3,417	831	35,221	62.00
65.00	06500	RESPIRATORY THERAPY	45,197	7,546	41,760	8,732	807,972	65.00
66.00	06600	PHYSICAL THERAPY	90,394	634	10,429	24,635	742,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,433	7,326	202,848	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	454	1,469	39,386	68.00
69.00	06900	ELECTROCARDIOLOGY	0	353	29,271	27,328	317,672	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,081	238	26,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,796	1,602	108,725	52,543	1,645,518	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	338,979	70,697	46,574	189,563	4,534,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,576,240	282,357	796,122	690,084	24,247,177	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	361,577	1,209	0	943	530,502	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	38,435	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,937,817	283,566	796,122	691,027	24,816,114	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	2,343,040					5.06
7.00	00700	OPERATION OF PLANT	238,807	2,529,298				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	870	20,693	29,904			8.00
9.00	00900	HOUSEKEEPING	47,633	19,593	2,671	526,768		9.00
10.00	01000	DIETARY	17,554	46,833	76	9,912	242,740	10.00
11.00	01100	CAFETERIA	51,366	0	323	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	104,013	69,075	0	14,619	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,857	43,734	0	9,256	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	235,715	699,150	7,896	147,966	186,548	30.00
31.00	03100	INTENSIVE CARE UNIT	125,830	20,493	3,570	4,337	31,845	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,632	149,197	1,502	31,576	0	50.00
51.00	05100	RECOVERY ROOM	7,365	15,045	0	3,184	0	51.00
51.01	05101	O/P TREATMENT ROOM	35,450	80,371	0	17,010	24,347	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	237,093	285,148	2,533	60,348	0	54.00
56.00	05600	RADIOISOTOPE	11,541	13,145	0	2,782	0	56.00
60.00	06000	LABORATORY	110,220	85,520	0	18,099	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,672	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	84,239	51,182	238	10,832	0	65.00
66.00	06600	PHYSICAL THERAPY	77,382	168,890	2,704	35,743	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,149	142,049	0	30,063	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,106	19,193	0	4,062	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,120	20,943	515	4,432	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,813	50,782	0	10,747	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	171,562	50,682	0	10,726	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	472,734	417,751	7,876	88,412	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,283,723	2,469,469	29,904	514,106	242,740	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	55,310	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	4,007	59,829	0	12,662	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,343,040	2,529,298	29,904	526,768	242,740	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
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	544,360					11.00
13.00	01300	NURSING ADMINISTRATION	40,650	1,225,992				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,612	0	703,978			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	105,569	452,285	34,933	4,130,902	0	30.00
31.00	03100	INTENSIVE CARE UNIT	53,821	230,467	8,938	1,686,189	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,295	0	50,507	1,649,651	0	50.00
51.00	05100	RECOVERY ROOM	3,744	0	1,837	101,815	0	51.00
51.01	05101	O/P TREATMENT ROOM	15,377	64,956	9,210	586,741	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,001	0	190,106	3,119,281	0	54.00
56.00	05600	RADIOISOTOPE	0	0	4,976	143,141	0	56.00
60.00	06000	LABORATORY	0	0	84,493	1,355,499	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	848	39,741	0	62.00
65.00	06500	RESPIRATORY THERAPY	40,249	0	8,907	1,003,619	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	25,130	1,052,055	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,473	403,582	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,499	68,246	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,090	0	27,877	412,649	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	243	91,564	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	32,627	0	53,599	1,964,714	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	111,654	478,284	193,402	6,304,309	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	542,689	1,225,992	703,978	24,113,698	0	118.00
	NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	1,671	0	0	587,483	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	114,933	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	544,360	1,225,992	703,978	24,816,114	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL		5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	4,130,902	30.00
31.00	03100	INTENSIVE CARE UNIT	1,686,189	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1,649,651	50.00
51.00	05100	RECOVERY ROOM	101,815	51.00
51.01	05101	O/P TREATMENT ROOM	586,741	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,119,281	54.00
56.00	05600	RADIOISOTOPE	143,141	56.00
60.00	06000	LABORATORY	1,355,499	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,741	62.00
65.00	06500	RESPIRATORY THERAPY	1,003,619	65.00
66.00	06600	PHYSICAL THERAPY	1,052,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	403,582	67.00
68.00	06800	SPEECH PATHOLOGY	68,246	68.00
69.00	06900	ELECTROCARDIOLOGY	412,649	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,964,714	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	6,304,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,113,698	118.00
		NONREIMBURSABLE COST CENTERS		
194.00	07950	PHYSICIAN PRACTICES	587,483	194.00
194.01	07951	MEDICAL OFFICE BUILDING	114,933	194.01
194.02	07952	VPCHC	0	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,816,114	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,802	20,075	21,877	0	5.01
5.02	00550	DATA PROCESSING	0	3,517	0	3,517	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	13,704	87,321	101,025	0	5.03
5.04	00570	ADMITTING	0	8,731	702	9,433	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	5,163	0	5,163	0	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	0	25,536	8,516	34,052	0	5.06
7.00	00700	OPERATION OF PLANT	0	372,231	7,148	379,379	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,172	395	7,567	0	8.00
9.00	00900	HOUSEKEEPING	0	6,791	3,551	10,342	0	9.00
10.00	01000	DIETARY	0	16,233	1,911	18,144	0	10.00
11.00	01100	CAFETERIA	0	61,103	8,146	69,249	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,942	302	24,244	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,159	177	15,336	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	242,333	21,781	264,114	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,103	32,371	39,474	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	51,713	31,947	83,660	0	50.00
51.00	05100	RECOVERY ROOM	0	5,215	1,749	6,964	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	27,858	2,430	30,288	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,836	28,238	127,074	0	54.00
56.00	05600	RADIOISOTOPE	0	4,556	0	4,556	0	56.00
60.00	06000	LABORATORY	0	29,642	0	29,642	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,740	10,622	28,362	0	65.00
66.00	06600	PHYSICAL THERAPY	0	58,539	1,492	60,031	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	49,236	0	49,236	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,653	0	6,653	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,259	471	7,730	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,602	0	17,602	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	17,567	1,065	18,632	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	144,797	15,700	160,497	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,347,733	286,110	1,633,843	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,347,733	286,110	1,633,843	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	21,877					5.01
5.02	00550	DATA PROCESSING	168	3,685				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	252	0	101,277			5.03
5.04	00570	ADMITTING	505	170	173	10,281		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	337	57	0	0	5,557	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,262	369	65	0	0	5.06
7.00	00700	OPERATION OF PLANT	1,767	738	14	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	66	0	0	8.00
9.00	00900	HOUSEKEEPING	84	28	8,159	0	0	9.00
10.00	01000	DIETARY	84	28	5	0	0	10.00
11.00	01100	CAFETERIA	505	57	23	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	337	113	2	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	757	227	5	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,142	312	12,848	2,917	276	30.00
31.00	03100	INTENSIVE CARE UNIT	505	28	8,394	677	71	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	589	113	27,332	1,286	399	50.00
51.00	05100	RECOVERY ROOM	168	0	0	40	15	51.00
51.01	05101	O/P TREATMENT ROOM	926	28	6,378	8	73	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094	255	8,427	1,042	1,501	54.00
56.00	05600	RADIOISOTOPE	84	0	85	23	39	56.00
60.00	06000	LABORATORY	421	28	0	1,133	667	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	44	7	62.00
65.00	06500	RESPIRATORY THERAPY	589	57	2,695	540	70	65.00
66.00	06600	PHYSICAL THERAPY	926	113	226	135	198	66.00
67.00	06700	OCCUPATIONAL THERAPY	673	0	0	31	59	67.00
68.00	06800	SPEECH PATHOLOGY	168	0	0	6	12	68.00
69.00	06900	ELECTROCARDIOLOGY	421	0	126	378	220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84	0	0	14	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	505	85	572	1,405	423	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,524	425	25,250	602	1,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,877	3,231	100,845	10,281	5,549	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	454	432	0	8	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,877	3,685	101,277	10,281	5,557	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	35,748					5.06
7.00	00700	OPERATION OF PLANT	3,644	385,542				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13	3,154	10,800			8.00
9.00	00900	HOUSEKEEPING	727	2,987	965	23,292		9.00
10.00	01000	DIETARY	268	7,139	27	438	26,133	10.00
11.00	01100	CAFETERIA	784	0	117	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,587	10,529	0	646	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	898	6,666	0	409	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,597	106,571	2,850	6,545	20,084	30.00
31.00	03100	INTENSIVE CARE UNIT	1,920	3,124	1,289	192	3,428	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,993	22,742	543	1,396	0	50.00
51.00	05100	RECOVERY ROOM	112	2,293	0	141	0	51.00
51.01	05101	O/P TREATMENT ROOM	541	12,251	0	752	2,621	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,618	43,465	915	2,668	0	54.00
56.00	05600	RADIOISOTOPE	176	2,004	0	123	0	56.00
60.00	06000	LABORATORY	1,682	13,036	0	800	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	56	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,285	7,802	86	479	0	65.00
66.00	06600	PHYSICAL THERAPY	1,181	25,744	977	1,580	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	323	21,653	0	1,329	0	67.00
68.00	06800	SPEECH PATHOLOGY	63	2,926	0	180	0	68.00
69.00	06900	ELECTROCARDIOLOGY	505	3,192	186	196	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43	7,741	0	475	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	2,618	7,725	0	474	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,209	63,678	2,845	3,909	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,843	376,422	10,800	22,732	26,133	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	844	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	61	9,120	0	560	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,748	385,542	10,800	23,292	26,133	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
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	70,735					11.00
13.00	01300	NURSING ADMINISTRATION	5,282	42,740				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,588	0	27,886			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,718	15,767	1,383	457,124	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,994	8,034	354	74,484	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,326	0	1,999	146,378	0	50.00
51.00	05100	RECOVERY ROOM	487	0	73	10,293	0	51.00
51.01	05101	O/P TREATMENT ROOM	1,998	2,264	365	58,493	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,096	0	7,525	206,680	0	54.00
56.00	05600	RADIOISOTOPE	0	0	197	7,287	0	56.00
60.00	06000	LABORATORY	0	0	3,345	50,754	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	34	141	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,230	0	353	47,548	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	995	92,106	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	296	73,600	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	59	10,067	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,051	0	1,104	15,109	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10	25,971	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	4,240	0	2,122	38,801	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	14,508	16,675	7,672	307,311	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,518	42,740	27,886	1,622,147	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	217	0	0	1,955	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	9,741	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	70,735	42,740	27,886	1,633,843	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL		5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	457,124	30.00
31.00	03100	INTENSIVE CARE UNIT	74,484	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	146,378	50.00
51.00	05100	RECOVERY ROOM	10,293	51.00
51.01	05101	O/P TREATMENT ROOM	58,493	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	206,680	54.00
56.00	05600	RADIOISOTOPE	7,287	56.00
60.00	06000	LABORATORY	50,754	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	141	62.00
65.00	06500	RESPIRATORY THERAPY	47,548	65.00
66.00	06600	PHYSICAL THERAPY	92,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,600	67.00
68.00	06800	SPEECH PATHOLOGY	10,067	68.00
69.00	06900	ELECTROCARDIOLOGY	15,109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,801	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	307,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,622,147	118.00
		NONREIMBURSABLE COST CENTERS		
194.00	07950	PHYSICIAN PRACTICES	1,955	194.00
194.01	07951	MEDICAL OFFICE BUILDING	9,741	194.01
194.02	07952	VPCHC	0	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,633,843	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	77,794					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		275,078				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,772,320			4.00
5.01	00540	NONPATIENT TELEPHONES	104	19,301	0	260		5.01
5.02	00550	DATA PROCESSING	203	0	0	2	130	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	791	83,955	0	3	0	5.03
5.04	00570	ADMITTING	504	675	388,235	6	6	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	298	0	21,622	4	2	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,474	8,188	677,077	15	13	5.06
7.00	00700	OPERATION OF PLANT	21,486	6,872	366,491	21	26	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	380	0	0	0	8.00
9.00	00900	HOUSEKEEPING	392	3,414	218,706	1	1	9.00
10.00	01000	DIETARY	937	1,837	59,255	1	1	10.00
11.00	01100	CAFETERIA	3,527	7,832	256,164	6	2	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	290	525,794	4	4	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	170	185,453	9	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	20,941	1,006,588	73	11	30.00
31.00	03100	INTENSIVE CARE UNIT	410	31,123	689,928	6	1	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	30,715	355,989	7	4	50.00
51.00	05100	RECOVERY ROOM	301	1,682	40,759	2	0	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	2,336	160,224	11	1	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	27,149	658,867	13	9	54.00
56.00	05600	RADIOISOTOPE	263	0	0	1	0	56.00
60.00	06000	LABORATORY	1,711	0	0	5	1	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,024	10,212	413,277	7	2	65.00
66.00	06600	PHYSICAL THERAPY	3,379	1,434	0	11	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	0	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	453	98,491	5	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	0	1	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	1,014	1,024	405,845	6	3	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,358	15,095	1,196,356	30	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,794	275,078	7,725,121	260	114	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	47,199	0	16	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	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)	1,347,733	286,110	2,643,172	96,280	2,937,817	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.324382	1.040105	0.340075	370.307692	22,598.592308	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	21,877	3,685	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	84.142308	28.346154	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (REQUISITIO)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	320,795					5.03
5.04	00570	ADMITTING	548	9,685,346				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	72,291,633			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	206	0	0	-2,343,040	22,473,074	5.06
7.00	00700	OPERATION OF PLANT	43	0	0	0	2,290,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210	0	0	0	8,341	8.00
9.00	00900	HOUSEKEEPING	25,845	0	0	0	456,871	9.00
10.00	01000	DIETARY	17	0	0	0	168,365	10.00
11.00	01100	CAFETERIA	73	0	0	0	492,671	11.00
13.00	01300	NURSING ADMINISTRATION	6	0	0	0	997,635	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15	0	0	0	564,519	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,695	2,750,563	3,582,459	0	2,260,840	30.00
31.00	03100	INTENSIVE CARE UNIT	26,589	637,587	916,600	0	1,206,888	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,573	1,211,268	5,179,668	0	1,252,942	50.00
51.00	05100	RECOVERY ROOM	0	37,793	188,400	0	70,640	51.00
51.01	05101	O/P TREATMENT ROOM	20,202	7,638	944,505	0	340,020	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,691	981,468	19,496,066	0	2,274,052	54.00
56.00	05600	RADIOISOTOPE	270	21,907	510,326	0	110,697	56.00
60.00	06000	LABORATORY	0	1,066,969	8,665,049	0	1,057,167	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	41,574	86,984	0	35,221	62.00
65.00	06500	RESPIRATORY THERAPY	8,537	508,032	913,445	0	807,972	65.00
66.00	06600	PHYSICAL THERAPY	717	126,877	2,577,198	0	742,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,600	766,377	0	202,848	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,522	153,694	0	39,386	68.00
69.00	06900	ELECTROCARDIOLOGY	399	356,094	2,858,839	0	317,672	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,149	24,892	0	26,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,812	1,322,704	5,496,745	0	1,645,518	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	79,979	566,601	19,831,775	0	4,534,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	319,427	9,685,346	72,193,022	-2,343,040	21,904,137	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	1,368	0	98,611	0	530,502	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	38,435	194.01
194.02	07952	VPCHC	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)	283,566	796,122	691,027		2,343,040	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.883948	0.082199	0.009559		0.104260	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,277	10,281	5,557		35,748	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.315706	0.001062	0.000077		0.001591	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	50,604					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	63,015				8.00
9.00	00900	HOUSEKEEPING	392	5,628	49,798			9.00
10.00	01000	DIETARY	937	160	937	5,633		10.00
11.00	01100	CAFETERIA	0	681	0	0	8,142	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	0	1,382	0	608	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	413	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	16,638	13,988	4,329	1,579	30.00
31.00	03100	INTENSIVE CARE UNIT	410	7,522	410	739	805	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	3,166	2,985	0	498	50.00
51.00	05100	RECOVERY ROOM	301	0	301	0	56	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	0	1,608	565	230	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,705	5,337	5,705	0	1,047	54.00
56.00	05600	RADIOISOTOPE	263	0	263	0	0	56.00
60.00	06000	LABORATORY	1,711	0	1,711	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,024	501	1,024	0	602	65.00
66.00	06600	PHYSICAL THERAPY	3,379	5,699	3,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	1,086	419	0	121	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	1,016	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	1,014	0	1,014	0	488	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,358	16,597	8,358	0	1,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,407	63,015	48,601	5,633	8,117	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	25	194.00
194.01	07951	MEDICAL OFFICE BUILDING	1,197	0	1,197	0	0	194.01
194.02	07952	VPCHC	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)	2,529,298	29,904	526,768	242,740	544,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.982175	0.474554	10.578096	43.092491	66.858266	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	385,542	10,800	23,292	26,133	70,735	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.618805	0.171388	0.467730	4.639269	8.687669	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

		Cost Center Description	NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME)	
			13.00	16.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION	89,029		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,193,022	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	32,844	3,582,459	30.00
31.00	03100	INTENSIVE CARE UNIT	16,736	916,600	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	5,179,668	50.00
51.00	05100	RECOVERY ROOM	0	188,400	51.00
51.01	05101	O/P TREATMENT ROOM	4,717	944,505	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,496,066	54.00
56.00	05600	RADIOISOTOPE	0	510,326	56.00
60.00	06000	LABORATORY	0	8,665,049	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	86,984	62.00
65.00	06500	RESPIRATORY THERAPY	0	913,445	65.00
66.00	06600	PHYSICAL THERAPY	0	2,577,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	766,377	67.00
68.00	06800	SPEECH PATHOLOGY	0	153,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,858,839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,496,745	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	34,732	19,831,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,029	72,193,022	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	194.01
194.02	07952	VPCHC	0	0	194.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,225,992	703,978	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.770704	0.009751	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,740	27,886	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.480068	0.000386	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | 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	4,130,902		4,130,902	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,686,189		1,686,189	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,649,651		1,649,651	0	0	50.00
51.00	05100	RECOVERY ROOM	101,815		101,815	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	586,741		586,741	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,119,281		3,119,281	0	0	54.00
56.00	05600	RADIOISOTOPE	143,141		143,141	0	0	56.00
60.00	06000	LABORATORY	1,355,499		1,355,499	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,741		39,741	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,003,619	0	1,003,619	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,052,055	0	1,052,055	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	403,582	0	403,582	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	68,246	0	68,246	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	412,649		412,649	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,564		91,564	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,964,714		1,964,714	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,304,309		6,304,309	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,058,206		1,058,206		0	92.00
200.00		Subtotal (see instructions)	25,171,904	0	25,171,904	0	0	200.00
201.00		Less Observation Beds	1,058,206		1,058,206		0	201.00
202.00		Total (see instructions)	24,113,698	0	24,113,698	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,776,229		2,776,229			30.00
31.00	03100	INTENSIVE CARE UNIT	916,600		916,600			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,208,168	3,968,400	5,176,568	0.318677	0.000000	50.00
51.00	05100	RECOVERY ROOM	37,793	150,607	188,400	0.540419	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	7,638	909,638	917,276	0.639656	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,468	18,514,329	19,495,797	0.159998	0.000000	54.00
56.00	05600	RADIOISOTOPE	21,907	488,419	510,326	0.280489	0.000000	56.00
60.00	06000	LABORATORY	1,066,969	7,598,080	8,665,049	0.156433	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	41,574	45,410	86,984	0.456877	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	508,032	405,413	913,445	1.098719	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	126,877	2,450,321	2,577,198	0.408217	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,600	736,777	766,377	0.526610	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,522	148,172	153,694	0.444038	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	356,094	2,481,635	2,837,729	0.145415	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,249	11,743	27,992	3.271077	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,704	4,174,041	5,496,745	0.357432	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	566,601	19,265,174	19,831,775	0.317889	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,096	796,673	810,769	1.305188	0.000000	92.00
200.00		Subtotal (see instructions)	10,004,121	62,144,832	72,148,953			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,004,121	62,144,832	72,148,953			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 1:49 pm
	Title XVIII	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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/30/2018 1:49 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	4,130,902		4,130,902	0	4,130,902	30.00
31.00	03100	INTENSIVE CARE UNIT	1,686,189		1,686,189	0	1,686,189	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,649,651		1,649,651	0	1,649,651	50.00
51.00	05100	RECOVERY ROOM	101,815		101,815	0	101,815	51.00
51.01	05101	O/P TREATMENT ROOM	586,741		586,741	0	586,741	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,119,281		3,119,281	0	3,119,281	54.00
56.00	05600	RADIOISOTOPE	143,141		143,141	0	143,141	56.00
60.00	06000	LABORATORY	1,355,499		1,355,499	0	1,355,499	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,741		39,741	0	39,741	62.00
65.00	06500	RESPIRATORY THERAPY	1,003,619	0	1,003,619	0	1,003,619	65.00
66.00	06600	PHYSICAL THERAPY	1,052,055	0	1,052,055	0	1,052,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	403,582	0	403,582	0	403,582	67.00
68.00	06800	SPEECH PATHOLOGY	68,246	0	68,246	0	68,246	68.00
69.00	06900	ELECTROCARDIOLOGY	412,649		412,649	0	412,649	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,564		91,564	0	91,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,964,714		1,964,714	0	1,964,714	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,304,309		6,304,309	0	6,304,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,058,206		1,058,206		1,058,206	92.00
200.00		Subtotal (see instructions)	25,171,904	0	25,171,904	0	25,171,904	200.00
201.00		Less Observation Beds	1,058,206		1,058,206		1,058,206	201.00
202.00		Total (see instructions)	24,113,698	0	24,113,698	0	24,113,698	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 1:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,776,229		2,776,229			30.00
31.00	03100	INTENSIVE CARE UNIT	916,600		916,600			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,208,168	3,968,400	5,176,568	0.318677	0.000000	50.00
51.00	05100	RECOVERY ROOM	37,793	150,607	188,400	0.540419	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	7,638	909,638	917,276	0.639656	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,468	18,514,329	19,495,797	0.159998	0.000000	54.00
56.00	05600	RADIOISOTOPE	21,907	488,419	510,326	0.280489	0.000000	56.00
60.00	06000	LABORATORY	1,066,969	7,598,080	8,665,049	0.156433	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	41,574	45,410	86,984	0.456877	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	508,032	405,413	913,445	1.098719	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	126,877	2,450,321	2,577,198	0.408217	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,600	736,777	766,377	0.526610	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,522	148,172	153,694	0.444038	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	356,094	2,481,635	2,837,729	0.145415	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,249	11,743	27,992	3.271077	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,704	4,174,041	5,496,745	0.357432	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	566,601	19,265,174	19,831,775	0.317889	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,096	796,673	810,769	1.305188	0.000000	92.00
200.00		Subtotal (see instructions)	10,004,121	62,144,832	72,148,953			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,004,121	62,144,832	72,148,953			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 1:49 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/30/2018 1:49 pm
	Title XVIII	Hospital	Cost

		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	146,378	5,176,568	0.028277	403,359	11,406	50.00
51.00	05100	RECOVERY ROOM	10,293	188,400	0.054634	17,185	939	51.00
51.01	05101	O/P TREATMENT ROOM	58,493	917,276	0.063768	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	206,680	19,495,797	0.010601	296,700	3,145	54.00
56.00	05600	RADIOISOTOPE	7,287	510,326	0.014279	13,719	196	56.00
60.00	06000	LABORATORY	50,754	8,665,049	0.005857	492,073	2,882	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	141	86,984	0.001621	25,726	42	62.00
65.00	06500	RESPIRATORY THERAPY	47,548	913,445	0.052053	287,415	14,961	65.00
66.00	06600	PHYSICAL THERAPY	92,106	2,577,198	0.035739	68,896	2,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,600	766,377	0.096036	15,378	1,477	67.00
68.00	06800	SPEECH PATHOLOGY	10,067	153,694	0.065500	3,195	209	68.00
69.00	06900	ELECTROCARDIOLOGY	15,109	2,837,729	0.005324	240,577	1,281	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,971	27,992	0.927801	15,696	14,563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,801	5,496,745	0.007059	697,253	4,922	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	307,311	19,831,775	0.015496	19,623	304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,101	810,769	0.144432	0	0	92.00
200.00		Total (lines 50 through 199)	1,207,640	68,456,124		2,596,795	58,789	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326

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

Worksheet D Part IV

Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		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	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,176,568	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	188,400	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	917,276	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,495,797	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	510,326	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	8,665,049	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	86,984	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	913,445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,577,198	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	766,377	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	153,694	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,837,729	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	27,992	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,496,745	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	19,831,775	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	810,769	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	68,456,124		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	403,359	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	17,185	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.000000	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	296,700	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	13,719	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	492,073	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	25,726	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	287,415	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	68,896	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	15,378	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,195	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	240,577	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	15,696	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	697,253	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	19,623	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,596,795	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		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	0.318677	0	1,383,827	0	0	50.00
51.00	05100	RECOVERY ROOM	0.540419	0	52,867	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.639656	0	476,376	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159998	0	6,156,772	183	0	54.00
56.00	05600	RADIOISOTOPE	0.280489	0	173,664	0	0	56.00
60.00	06000	LABORATORY	0.156433	0	2,963,493	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.456877	0	27,266	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.098719	0	107,014	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.408217	0	1,019,651	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526610	0	214,582	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	0	15,283	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145415	0	1,048,857	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.271077	0	9,771	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357432	0	1,934,327	2,415	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.317889	0	5,134,657	1,272	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.305188	0	511,963	0	0	92.00
200.00		Subtotal (see instructions)		0	21,230,370	3,870	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	21,230,370	3,870	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		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	440,994	0	50.00
51.00	05100	RECOVERY ROOM	28,570	0	51.00
51.01	05101	O/P TREATMENT ROOM	304,717	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	985,071	29	54.00
56.00	05600	RADIOISOTOPE	48,711	0	56.00
60.00	06000	LABORATORY	463,588	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,457	0	62.00
65.00	06500	RESPIRATORY THERAPY	117,578	0	65.00
66.00	06600	PHYSICAL THERAPY	416,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,001	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,786	0	68.00
69.00	06900	ELECTROCARDIOLOGY	152,520	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,962	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691,390	863	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	1,632,251	404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	668,208	0	92.00
200.00		Subtotal (see instructions)	6,114,043	1,296	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,114,043	1,296	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V

Component CCN: 15-Z326 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.318677	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.540419	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.639656	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159998	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.280489	0	0	0	0	56.00
60.00	06000	LABORATORY	0.156433	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.456877	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.098719	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.408217	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526610	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145415	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.271077	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357432	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.317889	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.305188	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	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	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1326
Component CCN: 15-Z326

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

Worksheet D
Part V
Date/Time Prepared:
5/30/2018 1:49 pm

Title XVIII | Swing Beds - SNF | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,131	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)	1,560	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	98	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)	918	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)	97	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	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)	4,130,902	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)	181,618	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,949,284	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)	3,949,284	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,853.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,701,284	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)	1,701,284	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,686,189	283	5,958.27	156	929,490	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)	973,093	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,603,867	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)	179,765	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)	179,765	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)	571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,853.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,058,206	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	457,124	4,130,902	0.110660	1,058,206	117,101	90.00
91.00	Nursing School cost	0	4,130,902	0.000000	1,058,206	0	91.00
92.00	Allied health cost	0	4,130,902	0.000000	1,058,206	0	92.00
93.00	All other Medical Education	0	4,130,902	0.000000	1,058,206	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,131	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)	1,560	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	98	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)	19	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	4,130,902	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)	181,618	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,949,284	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)	3,949,284	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,853.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	35,212	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)	35,212	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 Date/Time Prepared: 5/30/2018 1:49 pm

		Title XIX		Hospital	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,686,189	283	5,958.27	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)	24,972	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	60,184	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)	571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,853.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,058,206	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 1:49 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	457,124	4,130,902	0.110660	1,058,206	117,101	90.00
91.00	Nursing School cost	0	4,130,902	0.000000	1,058,206	0	91.00
92.00	Allied health cost	0	4,130,902	0.000000	1,058,206	0	92.00
93.00	All other Medical Education	0	4,130,902	0.000000	1,058,206	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,588,436		30.00
31.00	03100	INTENSIVE CARE UNIT		350,625		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.318677	403,359	128,541	50.00
51.00	05100	RECOVERY ROOM	0.540419	17,185	9,287	51.00
51.01	05101	O/P TREATMENT ROOM	0.639656	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159998	296,700	47,471	54.00
56.00	05600	RADIOISOTOPE	0.280489	13,719	3,848	56.00
60.00	06000	LABORATORY	0.156433	492,073	76,976	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.456877	25,726	11,754	62.00
65.00	06500	RESPIRATORY THERAPY	1.098719	287,415	315,788	65.00
66.00	06600	PHYSICAL THERAPY	0.408217	68,896	28,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526610	15,378	8,098	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	3,195	1,419	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145415	240,577	34,984	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.271077	15,696	51,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357432	697,253	249,221	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.317889	19,623	6,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.305188	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,596,795	973,093	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,596,795		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Swing Beds - SNF | 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.318677	107	34	50.00
51.00	05100	RECOVERY ROOM	0.540419	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.639656	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159998	1,296	207	54.00
56.00	05600	RADIOISOTOPE	0.280489	0	0	56.00
60.00	06000	LABORATORY	0.156433	10,044	1,571	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.456877	1,894	865	62.00
65.00	06500	RESPIRATORY THERAPY	1.098719	17,185	18,881	65.00
66.00	06600	PHYSICAL THERAPY	0.408217	27,865	11,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526610	8,480	4,466	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	302	134	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145415	322	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.271077	390	1,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357432	27,650	9,883	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.317889	1	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.305188	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		95,536	48,739	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)		95,536		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 Date/Time Prepared: 5/30/2018 1:49 pm

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		Title XIX		Hospital	Cost	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		27,522		30.00
31.00	03100	INTENSIVE CARE UNIT		9,145		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.318677	21,906	6,981	50.00
51.00	05100	RECOVERY ROOM	0.540419	695	376	51.00
51.01	05101	O/P TREATMENT ROOM	0.639656	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159998	18,971	3,035	54.00
56.00	05600	RADIOISOTOPE	0.280489	197	55	56.00
60.00	06000	LABORATORY	0.156433	17,351	2,714	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.456877	113	52	62.00
65.00	06500	RESPIRATORY THERAPY	1.098719	4,165	4,576	65.00
66.00	06600	PHYSICAL THERAPY	0.408217	240	98	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526610	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145415	2,284	332	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.271077	122	399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357432	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.317889	19,989	6,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.305188	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		86,033	24,972	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)		86,033		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XIX | Swing Beds - SNF | 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.318677	0	0	50.00
51.00	05100	RECOVERY ROOM	0.540419	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.639656	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159998	0	0	54.00
56.00	05600	RADIOISOTOPE	0.280489	0	0	56.00
60.00	06000	LABORATORY	0.156433	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.456877	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.098719	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.408217	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.526610	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.444038	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145415	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.271077	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357432	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.317889	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.305188	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 1:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,115,339	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,115,339	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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	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 (see instructions)	6,176,492	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	61,872	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,636,824	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)	2,477,796	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)	2,477,796	30.00
31.00	Primary payer payments	159	31.00
32.00	Subtotal (line 30 minus line 31)	2,477,637	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)	694,347	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	451,326	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	694,347	36.00
37.00	Subtotal (see instructions)	2,928,963	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,928,963	40.00
40.01	Sequestration adjustment (see instructions)	58,579	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,048,303	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	822,081	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: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		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		2,417,097		2,048,303	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	07/28/2017	153,300		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)		153,300		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)		2,570,397		2,048,303	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		662,790		822,081	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,233,187		2,870,384	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: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Swing Beds - SNF | Cost

		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		195,772		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		195,772		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		26,370		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		222,142		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/30/2018 1:49 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2
Component CCN: 15-Z326 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	181,563	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	49,226	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	97	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	230,789	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	230,789	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	230,789	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,113	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	226,676	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	226,676	0	19.00
19.01	Sequestration adjustment (see instructions)	4,534	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	195,772	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	26,370	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1326 | Component CCN: 15-Z326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/30/2018 1:49 pm

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part V Date/Time Prepared: 5/30/2018 1:49 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,603,867	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,603,867	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,639,906	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,639,906	19.00
20.00	Deductibles (exclude professional component)	373,660	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,266,246	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,266,246	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	50,653	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	32,924	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,653	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,299,170	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,299,170	30.00
30.01	Sequestration adjustment (see instructions)	65,983	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,570,397	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	662,790	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 1:49 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		60,184		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		60,184	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		60,184	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		36,667		8.00
9.00	Ancillary service charges		86,033	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		122,700	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		122,700	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		62,516	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		60,184	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		60,184	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		60,184	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		60,184	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		60,184	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		60,184	0	40.00
41.00	Interim payments		44,447	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		15,737	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/30/2018 1:49 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	-656	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,416,162	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	315,872	0	0	0	7.00
8.00	Prepaid expenses	28,875,083	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	31,606,461	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	609,760	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,424,619	0	0	0	15.00
16.00	Accumulated depreciation	-12,908,997	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,839,092	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,964,474	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,570,935	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	700,209	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,082,055	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-315,344	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,466,920	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,269,548	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,269,548	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,736,468	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	35,834,467				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)	35,834,467	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,570,935	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 15-1326	Period: From 01/01/2017 To 12/31/2017	Worksheet G-1 Date/Time Prepared: 5/30/2018 1:49 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		35,385,203		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		449,264				2.00
3.00	Total (sum of line 1 and line 2)		35,834,467		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		35,834,467		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35,834,467		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2018 1:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,776,229		2,776,229	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,776,229		2,776,229	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	916,600		916,600	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)	916,600		916,600	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,692,829		3,692,829	17.00
18.00	Ancillary services	5,733,695	42,079,885	47,813,580	18.00
19.00	Outpatient services	580,697	20,061,847	20,642,544	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	142,680	142,680	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,007,221	62,284,412	72,291,633	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,257,906		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)		20,257,906		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1326 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/30/2018 1:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,291,633	1.00
2.00	Less contractual allowances and discounts on patients' accounts	49,917,258	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,374,375	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,257,906	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,116,469	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	400,773	24.00
24.01	NON OPERATING	5,000	24.01
24.02	INTEREST INCOME	3,006	24.02
25.00	Total other income (sum of lines 6-24)	408,779	25.00
26.00	Total (line 5 plus line 25)	2,525,248	26.00
27.00	ALLOCATED EXPENSES	2,075,984	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,075,984	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	449,264	29.00