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: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet S Parts I-III Date/Time Prepared: 7/31/2018 2:41 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/31/2018 Time: 2:41 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 KOSCIUSKO COMMUNITY HOSPITAL (15-0133) for the cost reporting period beginning 03/01/2017 and ending 02/28/2018 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	110,107	56,104	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	110,107	56,104	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I | Date/Time Prepared: 7/31/2018 2:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2101 EAST DUBOIS DRIVE	PO Box:			1.00
2.00	City: WARSAW	State: IN	Zip Code: 46580-	County: KOSCIUSKO	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	KOSCIUSKO COMMUNITY HOSPITAL	150133	99915	1	07/01/1966	O	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	03/01/2017	02/28/2018	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	212	1,069	1	4	527	97	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2018 2:39 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2018 2:39 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2018 2:39 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I | Date/Time Prepared: 7/31/2018 2:39 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	410,681	128,987	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2018 2:39 pm

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.		Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD		PO Box:		142.00
143.00	City: FRANKLIN		State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	12/29/2014	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part II | Date/Time Prepared: 7/31/2018 2:39 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/18/2018	Y	06/18/2018	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part II | Date/Time Prepared: 7/31/2018 2:39 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.	Y	12/31/2015	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COREY	WATKINS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4497	COREY_WATKINS@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet S-2 Part II Date/Time Prepared: 7/31/2018 2:39 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part I Date/Time Prepared: 7/31/2018 2:39 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	58	21,170	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		58	21,170	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		72	26,280	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		72				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

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,966	1,046	7,927			1.00
2.00	HMO and other (see instructions)	2,078	197				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,966	1,046	7,927			7.00
8.00	INTENSIVE CARE UNIT	483	204	1,272			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		463	951			13.00
14.00	Total (see instructions)	3,449	1,713	10,150	0.00	395.38	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	395.38	27.00
28.00	Observation Bed Days		0	2,338			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)	171	0	605			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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part I | Date/Time Prepared: 7/31/2018 2:39 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	930	437	2,915	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	930	437	2,915	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 WAGE INDEX INFORMATION | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part II Date/Time Prepared: 7/31/2018 2:39 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	23,054,508	0	23,054,508	822,390.00	28.03	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		37,157	144,993	182,150	7,547.00	24.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		362,630	0	362,630	5,000.00	72.53	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		113,971	0	113,971	972.00	117.25	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		2,504,996	0	2,504,996	74,534.00	33.61	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,675,734	0	4,675,734			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		112,875	0	112,875			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	175,622	0	175,622	6,248.00	28.11	26.00
27.00	Administrative & General	5.00	3,842,986	-365,618	3,477,368	128,236.00	27.12	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part II Date/Time Prepared: 7/31/2018 2:39 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		6,132	0	6,132	65.00	94.34	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	543,694	0	543,694	24,712.00	22.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	460,527	0	460,527	34,094.00	13.51	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	106,846	-92,303	14,543	884.00	16.45	34.00
35.00	Dietary under contract (see instructions)		580,294	0	580,294	26,045.00	22.28	35.00
36.00	Cafeteria	11.00	0	92,303	92,303	5,609.00	16.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,215,679	220,625	1,436,304	38,977.00	36.85	38.00
39.00	Central Services and Supply	14.00	166,007	0	166,007	8,753.00	18.97	39.00
40.00	Pharmacy	15.00	871,478	0	871,478	19,556.00	44.56	40.00
41.00	Medical Records & Medical Records Library	16.00	289,646	0	289,646	14,754.00	19.63	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part III Date/Time Prepared: 7/31/2018 2:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		23,640,934	0	23,640,934	848,500.00	27.86	1.00
2.00	Excluded area salaries (see instructions)		37,157	144,993	182,150	7,547.00	24.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,603,777	-144,993	23,458,784	840,953.00	27.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,981,597	0	2,981,597	80,506.00	37.04	4.00
5.00	Subtotal wage-related costs (see inst.)		4,675,734	0	4,675,734	0.00	19.93	5.00
6.00	Total (sum of lines 3 thru 5)		31,261,108	-144,993	31,116,115	921,459.00	33.77	6.00
7.00	Total overhead cost (see instructions)		8,258,911	-144,993	8,113,918	307,933.00	26.35	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part IV Date/Time Prepared: 7/31/2018 2:39 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	411,873	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,474,676	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	12,601	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	19,832	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	230	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	20,004	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	200,710	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,294,584	17.00
18.00	Medicare Taxes - Employers Portion Only	302,766	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	51,818	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,789,094	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part V Date/Time Prepared: 7/31/2018 2:39 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	362,630	4,789,094	1.00
2.00	Hospital	362,630	4,789,094	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-10 | Date/Time Prepared: 7/31/2018 2:39 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)	0.115628	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,563,697	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	65,914,947	6.00
7.00	Medicaid cost (line 1 times line 6)	7,621,613	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)	57,916	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)	57,916	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)	5,965,406	3,192	5,968,598	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	689,768	3,192	692,960	21.00
22.00	Payments received from patients for amounts previously written off as charity care	300	17	317	22.00
23.00	Cost of charity care (line 21 minus line 22)	689,468	3,175	692,643	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,023,766	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	198,442	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	305,295	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,718,471	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	536,812	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,229,455	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,287,371	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,587,290	1,587,290	865,440	2,452,730	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,555,681	3,555,681	1,047,468	4,603,149	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	175,622	128,202	303,824	3,305,438	3,609,262	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	3,842,986	17,361,728	21,204,714	-10,045,460	11,159,254	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	4,732,717	4,732,717	5.02
7.00	00700	OPERATION OF PLANT	543,694	1,663,493	2,207,187	-677	2,206,510	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	309,745	309,745	0	309,745	8.00
9.00	00900	HOUSEKEEPING	460,527	270,473	731,000	0	731,000	9.00
10.00	01000	DIETARY	106,846	1,153,665	1,260,511	-1,089,471	171,040	10.00
11.00	01100	CAFETERIA	0	0	0	1,088,937	1,088,937	11.00
13.00	01300	NURSING ADMINISTRATION	1,215,679	156,962	1,372,641	217,736	1,590,377	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	166,007	2,937,016	3,103,023	-2,586,843	516,180	14.00
15.00	01500	PHARMACY	871,478	7,595,427	8,466,905	-7,150,839	1,316,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289,646	518,139	807,785	-1,703	806,082	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,827,991	2,188,669	6,016,660	-677,444	5,339,216	30.00
31.00	03100	INTENSIVE CARE UNIT	1,030,500	163,671	1,194,171	-1,447	1,192,724	31.00
43.00	04300	NURSERY	0	0	0	191,955	191,955	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,406,568	1,335,561	2,742,129	5,818	2,747,947	50.00
51.00	05100	RECOVERY ROOM	715,131	136,014	851,145	-1,097	850,048	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	481,523	481,523	52.00
53.00	05300	ANESTHESIOLOGY	0	1,001,034	1,001,034	-13,949	987,085	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,191,136	2,832,987	5,024,123	-2,491,765	2,532,358	54.00
54.01	05401	ULTRASOUND	395,298	331,986	727,284	-727,284	0	54.01
54.02	05402	ONCOLOGY	0	0	0	2,594,261	2,594,261	54.02
56.00	05600	RADIOISOTOPE	163,357	210,966	374,323	0	374,323	56.00
57.00	05700	CT SCAN	272,718	323,538	596,256	-34,317	561,939	57.00
58.00	05800	MRI	190,881	191,972	382,853	0	382,853	58.00
60.00	06000	LABORATORY	1,513,443	2,088,994	3,602,437	-172,347	3,430,090	60.00
65.00	06500	RESPIRATORY THERAPY	431,967	74,016	505,983	132,026	638,009	65.00
66.00	06600	PHYSICAL THERAPY	729,601	1,224,554	1,954,155	-2,226	1,951,929	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,342	160,183	188,525	-713	187,812	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,254	20,254	0	20,254	68.00
69.00	06900	ELECTROCARDIOLOGY	264,648	25,848	290,496	0	290,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	691,733	691,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,838,478	1,838,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,956,301	6,956,301	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	85,998	46,720	132,718	-132,718	0	76.01
76.03	03951	WOUND CARE	83,583	46,012	129,595	-129,595	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	526,832	-222,890	303,942	126,500	430,442	90.00
91.00	09100	EMERGENCY	1,486,872	1,328,678	2,815,550	-47,125	2,768,425	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)	23,017,351	50,746,588	73,763,939	-1,030,689	72,733,250	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,157	23,441	60,598	-1,273	59,325	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-2,043	-2,043	0	-2,043	192.00
192.01	19201	WELLNESS CENTER	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	1,031,962	1,031,962	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	23,054,508	50,767,986	73,822,494	0	73,822,494	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,999,629	4,452,359		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	208,764	4,811,913		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,537	3,607,725		4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	-258,717	10,900,537		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,486,259	3,246,458		5.02
7.00	00700	OPERATION OF PLANT	0	2,206,510		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	309,745		8.00
9.00	00900	HOUSEKEEPING	0	731,000		9.00
10.00	01000	DIETARY	0	171,040		10.00
11.00	01100	CAFETERIA	-198,754	890,183		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,590,377		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	516,180		14.00
15.00	01500	PHARMACY	0	1,316,066		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26,993	779,089		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,534,878	3,804,338		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,192,724		31.00
43.00	04300	NURSERY	0	191,955		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,747,947		50.00
51.00	05100	RECOVERY ROOM	0	850,048		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	481,523		52.00
53.00	05300	ANESTHESIOLOGY	-987,085	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,048,842	1,483,516		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	05402	ONCOLOGY	0	2,594,261		54.02
56.00	05600	RADIOISOTOPE	-330	373,993		56.00
57.00	05700	CT SCAN	-13,388	548,551		57.00
58.00	05800	MRI	-25,579	357,274		58.00
60.00	06000	LABORATORY	-7,581	3,422,509		60.00
65.00	06500	RESPIRATORY THERAPY	0	638,009		65.00
66.00	06600	PHYSICAL THERAPY	0	1,951,929		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187,812		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,254		68.00
69.00	06900	ELECTROCARDIOLOGY	0	290,496		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	691,733		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,838,478		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,956,301		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	430,442		90.00
91.00	09100	EMERGENCY	-775,540	1,992,885		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)	-4,157,090	68,576,160		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,325		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	93,688	91,645		192.00
192.01	19201	WELLNESS CENTER	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	1,031,962		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,063,402	69,759,092		200.00

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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,306,598	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	3,306,598	
	B - OXYGEN				
1.00		0.00	0	0	1.00
	0		0	0	
	C - LEASE AND RENTAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	206,570	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,019,112	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	1,225,682	
	D - OTHER CAPITAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	91,893	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	566,977	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,356	3.00
	0		0	687,226	
	E - MARKETING				
1.00	MARKETING	194.01	144,993	886,969	1.00
	0		144,993	886,969	
	F - CNO COST				
1.00	NURSING ADMINISTRATION	13.00	220,625	0	1.00
	0		220,625	0	
	G - CHARGABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	691,733	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,838,478	2.00
3.00		0.00	0	0	3.00
	0		0	2,530,211	
	H - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,956,301	1.00
	0		0	6,956,301	
	I - LABOR AND DELIVERY				
1.00	NURSERY	43.00	162,445	29,510	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	407,497	74,026	2.00
	0		569,942	103,536	
	J - MISC DEPARTMENTS				
1.00	CLINIC	90.00	83,583	46,012	1.00
2.00	RESPIRATORY THERAPY	65.00	85,998	46,720	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	1,506,561	3,226,156	3.00
4.00	OPERATING ROOM	50.00	0	13,949	4.00
	0		1,676,142	3,332,837	
	K - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	395,298	331,986	1.00
2.00	ONCOLOGY	54.02	884,572	1,709,689	2.00
	0		1,279,870	2,041,675	
	L - DIETARY				
1.00	CAFETERIA	11.00	92,303	996,634	1.00
	0		92,303	996,634	
	M - MOB UTILITIES				
1.00		0.00	0	0	1.00
	0		0	0	
500.00	Grand Total: Increases		3,983,875	22,067,669	500.00

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-6 | Date/Time Prepared: 7/31/2018 2:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	NURSING ADMINISTRATION	13.00	0	2	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,306,591	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	5	0		3.00
	0		0	3,306,598			
	B - OXYGEN						
1.00		0.00	0	0	0		1.00
	0		0	0			
	C - LEASE AND RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,160	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	66,339	10		2.00
3.00	OPERATION OF PLANT	7.00	0	677	0		3.00
4.00	DIETARY	10.00	0	534	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,887	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	64,340	0		6.00
7.00	PHARMACY	15.00	0	194,538	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,698	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	3,966	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,447	0		10.00
11.00	OPERATING ROOM	50.00	0	605	0		11.00
12.00	RECOVERY ROOM	51.00	0	1,097	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	624,788	0		13.00
14.00	CT SCAN	57.00	0	34,317	0		14.00
15.00	LABORATORY	60.00	0	172,347	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	510	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,226	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	713	0		18.00
19.00	CLINIC	90.00	0	3,095	0		19.00
20.00	EMERGENCY	91.00	0	47,125	0		20.00
21.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,273	0		21.00
	0		0	1,225,682			
	D - OTHER CAPITAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	687,226	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	687,226			
	E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	144,993	886,969	0		1.00
	0		144,993	886,969			
	F - CNO COST						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	220,625	0	0		1.00
	0		220,625	0			
	G - CHARGABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	7,526	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,522,503	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	182	0		3.00
	0		0	2,530,211			
	H - DRUGS						
1.00	PHARMACY	15.00	0	6,956,301	0		1.00
	0		0	6,956,301			
	I - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	569,942	103,536	0		1.00
2.00		0.00	0	0	0		2.00
	0		569,942	103,536			
	J - MISC DEPARTMENTS						
1.00	WOUND CARE	76.03	83,583	46,012	0		1.00
2.00	SLEEP LAB	76.01	85,998	46,720	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	1,506,561	3,226,156	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	13,949	0		4.00
	0		1,676,142	3,332,837			
	K - RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	884,572	1,709,689	0		1.00
2.00	ULTRASOUND	54.01	395,298	331,986	0		2.00
	0		1,279,870	2,041,675			

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-6 | Date/Time Prepared: 7/31/2018 2:39 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - DIETARY						
1.00	DIETARY	10.00	92,303	996,634	0		1.00
	0		92,303	996,634			
	M - MOB UTILITIES						
1.00		0.00	0	0	0		1.00
	0		0	0			
500.00	Grand Total: Decreases		3,983,875	22,067,669			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-7 Part I | Date/Time Prepared: 7/31/2018 2:39 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	158,709	0	0	0	0	1.00
2.00	Land Improvements	1,539,273	116,412	0	116,412	80,787	2.00
3.00	Buildings and Fixtures	55,217,636	2,654,441	0	2,654,441	6,967	3.00
4.00	Building Improvements	161,932	0	0	0	23,174	4.00
5.00	Fixed Equipment	4,129,602	421,531	0	421,531	8,092	5.00
6.00	Movable Equipment	42,091,718	5,120,349	0	5,120,349	521,071	6.00
7.00	HIT designated Assets	2,272,703	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	105,571,573	8,312,733	0	8,312,733	640,091	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	105,571,573	8,312,733	0	8,312,733	640,091	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	158,709	0	1.00
2.00	Land Improvements	1,574,898	0	2.00
3.00	Buildings and Fixtures	57,865,110	0	3.00
4.00	Building Improvements	138,758	0	4.00
5.00	Fixed Equipment	4,543,041	0	5.00
6.00	Movable Equipment	46,690,996	0	6.00
7.00	HIT designated Assets	2,272,703	0	7.00
8.00	Subtotal (sum of lines 1-7)	113,244,215	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	113,244,215	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-7 Part II Date/Time Prepared: 7/31/2018 2:39 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,587,290	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,555,681	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,142,971	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,587,290		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,555,681		2.00
3.00	Total (sum of lines 1-2)	0	5,142,971		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-7 Part III Date/Time Prepared: 7/31/2018 2:39 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	59,737,475	0	59,737,475	0.527510	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53,506,740	0	53,506,740	0.472490	0	2.00
3.00	Total (sum of lines 1-2)	113,244,215	0	113,244,215	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,354,679	205,672	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,543,045	1,019,112	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,897,724	1,224,784	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,165,162	91,893	566,977	67,976	4,452,359	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,356	0	221,400	4,811,913	2.00
3.00	Total (sum of lines 1-2)	1,165,162	120,249	566,977	289,376	9,264,272	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8 | Date/Time Prepared: 7/31/2018 2:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-816	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-25,981	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,422,018			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	453,294			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-198,566	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-26,993	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-188	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	767,389	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	18,082	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8 | Date/Time Prepared: 7/31/2018 2:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	RENTAL INCOME	B	-898	CAP REL COSTS-BLDG & FIXT	1.00	10	34.00
35.00	MISC INCOME	B	-153,152	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
37.00	PATIENT PHONE WAGE COST	A	-7,152	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	PATIENT PHONE BENEFIT COSTS	A	-1,537	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	PATIENT PHONE EXPENSE	A	-14,621	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	39.00
40.00	PATIENT PHONE DEPRECIATION	A	-1,555	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
41.00	PATIENT TV - DEPRECIATION	A	-3,182	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	MARKETING	A	-53,008	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00	PHYSICIAN RECRUITING	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	43.00
44.00	CHARITABLE CONTRIBUTIONS	A	-2,500	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
45.01	MINORITY INTEREST	A	-361,778	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.01
45.02	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-10,998	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.02
45.03	TRANSPORTATION COSTS	A	-2,626	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.03
45.04	LEGAL FEES	A	-103,244	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.04
45.05	POB DEPRECIATION	A	93,688	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.05
45.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.06
45.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.07
45.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.08
45.09	MEALS AND ENTERTAINMENT	A	-5,042	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,063,402				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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8-1 | Date/Time Prepared: 7/31/2018 2:39 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL-	1,165,162	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	33,985	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	9,515	0	3.00
4.00	5.01	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	500,446	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	33,991	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	211,885	0	4.05
4.06	5.01	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,964,773	0	4.06
4.07	5.01	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS (SEE EXHIB	539,668	0	4.07
4.08	0.00		CIG LEASED EQUIPMENT (SEE EX	0	0	4.08
4.09	5.02	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	819,565	4.09
4.10	5.01	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	6,816	4.10
4.11	5.01	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	61,391	4.11
4.12	5.01	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1,421,340	4.12
4.13	5.01	OTHER ADMINISTRATIVE AND GEN	SSC ALLOCATION	1,003,888	1,122,036	4.13
4.14	5.01	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	0	374,984	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	5.01	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	34,722	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	5.02	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	562,476	4.21
4.22	0.00		EBOS FEES	0	0	4.22
4.23	5.02	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	77,776	4.23
4.24	5.01	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS (PER	0	524,244	4.24
4.25	5.02	OTHER ADMINISTRATIVE AND GEN	CIG LEASED EQUIPMENT (PER EX	0	4,669	4.25
4.26	0.00		LAUNDRY CAPITAL	0	0	4.26
4.27	0.00		LAUNDRY OPERATING	0	0	4.27
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,463,313	5,010,019	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	B		0.00	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00	C		0.00	HOSPITAL LAUNDR	20.00	7.00
8.00	C		0.00	PASI	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet A-8-1 Date/Time Prepared: 7/31/2018 2:39 pm

	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	

(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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8-1 | Date/Time Prepared: 7/31/2018 2:39 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	1,165,162	11		1.00
2.00	33,985	14		2.00
3.00	9,515	14		3.00
4.00	500,446	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	33,991	14		4.04
4.05	211,885	14		4.05
4.06	1,964,773	0		4.06
4.07	539,668	0		4.07
4.08	0	0		4.08
4.09	-819,565	0		4.09
4.10	-6,816	0		4.10
4.11	-61,391	0		4.11
4.12	-1,421,340	0		4.12
4.13	-118,148	0		4.13
4.14	-374,984	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	-34,722	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	-562,476	0		4.21
4.22	0	0		4.22
4.23	-77,776	0		4.23
4.24	-524,244	0		4.24
4.25	-4,669	0		4.25
4.26	0	9		4.26
4.27	0	0		4.27
5.00	453,294			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	HOSPITAL MANAGEMENT		6.00
7.00	LAUNDRY SERVICES		7.00
8.00	DEBT COLLECTION		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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8-2 | Date/Time Prepared: 7/31/2018 2:39 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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	987,085	987,085	0	0	0	2.00
3.00	60.00	LABORATORY	7,581	7,581	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,048,842	1,048,842	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	57.00	CT SCAN	13,388	13,388	0	0	0	6.00
7.00	58.00	MRI	25,579	25,579	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	330	330	0	0	0	8.00
9.00	91.00	EMERGENCY	775,540	775,540	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	1,534,878	1,534,878	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	28,795	28,795	0	0	0	12.00
200.00			4,422,018	4,422,018	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	58.00	MRI	0	0	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	12.00
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	50.00	OPERATING ROOM	0	0	0	0		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	987,085		2.00
3.00	60.00	LABORATORY	0	0	0	7,581		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,048,842		4.00
5.00	0.00		0	0	0	0		5.00
6.00	57.00	CT SCAN	0	0	0	13,388		6.00
7.00	58.00	MRI	0	0	0	25,579		7.00
8.00	56.00	RADIOISOTOPE	0	0	0	330		8.00
9.00	91.00	EMERGENCY	0	0	0	775,540		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,534,878		10.00
11.00	90.00	CLINIC	0	0	0	0		11.00
12.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	28,795		12.00
200.00			0	0	0	4,422,018		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,452,359	4,452,359				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,811,913		4,811,913			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,607,725	10,976	11,863	3,630,564		4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	10,900,537	205,134	221,700	312,739	11,640,110	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	3,246,458	331,243	357,993	239,070	4,174,764	5.02
7.00	00700	OPERATION OF PLANT	2,206,510	327,168	353,589	86,277	2,973,544	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	309,745	6,811	7,361	0	323,917	8.00
9.00	00900	HOUSEKEEPING	731,000	14,370	15,531	73,079	833,980	9.00
10.00	01000	DIETARY	171,040	39,479	42,667	2,308	255,494	10.00
11.00	01100	CAFETERIA	890,183	33,167	35,846	14,647	973,843	11.00
13.00	01300	NURSING ADMINISTRATION	1,590,377	8,593	9,287	227,921	1,836,178	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	516,180	22,815	24,658	26,343	589,996	14.00
15.00	01500	PHARMACY	1,316,066	22,429	24,241	138,291	1,501,027	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	779,089	31,442	33,981	45,963	890,475	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,804,338	477,398	515,950	517,014	5,314,700	30.00
31.00	03100	INTENSIVE CARE UNIT	1,192,724	106,710	115,328	163,526	1,578,288	31.00
43.00	04300	NURSERY	191,955	10,216	11,041	25,778	238,990	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,747,947	198,698	214,744	223,203	3,384,592	50.00
51.00	05100	RECOVERY ROOM	850,048	9,365	10,121	113,481	983,015	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	481,523	39,070	42,225	64,664	627,482	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,483,516	147,993	159,945	270,062	2,061,516	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	2,594,261	127,244	137,520	140,369	2,999,394	54.02
56.00	05600	RADIOISOTOPE	373,993	5,800	6,269	25,922	411,984	56.00
57.00	05700	CT SCAN	548,551	28,684	31,000	43,277	651,512	57.00
58.00	05800	MRI	357,274	38,048	41,121	30,290	466,733	58.00
60.00	06000	LABORATORY	3,422,509	69,184	74,771	240,162	3,806,626	60.00
65.00	06500	RESPIRATORY THERAPY	638,009	34,314	37,085	82,194	791,602	65.00
66.00	06600	PHYSICAL THERAPY	1,951,929	108,697	117,474	115,777	2,293,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,812	1,135	1,227	4,497	194,671	67.00
68.00	06800	SPEECH PATHOLOGY	20,254	1,135	1,227	0	22,616	68.00
69.00	06900	ELECTROCARDIOLOGY	290,496	568	613	41,996	333,673	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	691,733	0	0	0	691,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,838,478	0	0	0	1,838,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,956,301	0	0	0	6,956,301	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	430,442	42,089	45,488	96,864	614,883	90.00
91.00	09100	EMERGENCY	1,992,885	152,103	164,386	235,946	2,545,320	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)	68,576,160	2,652,078	2,866,252	3,601,660	64,801,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,325	6,981	7,545	5,896	79,747	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	91,645	1,489,809	1,610,117	0	3,191,571	192.00
192.01	19201	WELLNESS CENTER	0	133,862	144,672	0	278,534	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,031,962	23,735	25,652	23,008	1,104,357	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	145,894	157,675	0	303,569	194.03
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)	69,759,092	4,452,359	4,811,913	3,630,564	69,759,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	11,640,110					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	836,126	5,010,890	5,010,890			5.02
7.00	00700	OPERATION OF PLANT	595,544	3,569,088	293,582	3,862,670		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,874	388,791	31,981	7,353	428,125	8.00
9.00	00900	HOUSEKEEPING	167,030	1,001,010	82,340	15,514	0	9.00
10.00	01000	DIETARY	51,171	306,665	25,225	42,621	0	10.00
11.00	01100	CAFETERIA	195,042	1,168,885	96,149	35,808	0	11.00
13.00	01300	NURSING ADMINISTRATION	367,752	2,203,930	181,289	9,277	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,165	708,161	58,251	24,632	5,682	14.00
15.00	01500	PHARMACY	300,627	1,801,654	148,199	24,215	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178,345	1,068,820	87,918	33,945	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,064,433	6,379,133	524,728	515,403	100,185	30.00
31.00	03100	INTENSIVE CARE UNIT	316,101	1,894,389	155,827	115,205	26,973	31.00
43.00	04300	NURSERY	47,865	286,855	23,596	11,029	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	677,869	4,062,461	334,166	214,517	65,506	50.00
51.00	05100	RECOVERY ROOM	196,879	1,179,894	97,055	10,110	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	125,673	753,155	61,952	42,180	46,240	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,882	2,474,398	203,537	159,775	92,498	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	600,722	3,600,116	296,135	137,374	0	54.02
56.00	05600	RADIOISOTOPE	82,513	494,497	40,676	6,262	0	56.00
57.00	05700	CT SCAN	130,485	781,997	64,325	30,967	0	57.00
58.00	05800	MRI	93,478	560,211	46,081	41,077	0	58.00
60.00	06000	LABORATORY	762,395	4,569,021	375,834	74,692	0	60.00
65.00	06500	RESPIRATORY THERAPY	158,543	950,145	78,156	37,046	0	65.00
66.00	06600	PHYSICAL THERAPY	459,420	2,753,297	226,478	117,350	29,387	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,989	233,660	19,220	1,225	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,530	27,146	2,233	1,225	0	68.00
69.00	06900	ELECTROCARDIOLOGY	66,828	400,501	32,944	613	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	138,541	830,274	68,296	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	368,212	2,206,690	181,516	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,393,199	8,349,500	686,809	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	123,149	738,032	60,708	45,440	7,707	90.00
91.00	09100	EMERGENCY	509,779	3,055,099	251,303	164,211	53,947	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)	10,647,161	63,808,365	4,836,509	1,919,066	428,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,972	95,719	7,874	7,537	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	639,211	3,830,782	0	1,608,417	0	192.00
192.01	19201	WELLNESS CENTER	55,785	334,319	27,500	144,518	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	221,182	1,325,539	109,035	25,624	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	60,799	364,368	29,972	157,508	0	194.03
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)	11,640,110	69,759,092	5,010,890	3,862,670	428,125	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,098,864					9.00
10.00	01000	DIETARY	12,761	387,272				10.00
11.00	01100	CAFETERIA	10,721	0	1,311,563			11.00
13.00	01300	NURSING ADMINISTRATION	2,777	0	82,115	2,479,388		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,375	0	18,447	0	822,548	14.00
15.00	01500	PHARMACY	7,250	0	41,189	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,163	0	31,067	0	1,025	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,310	276,248	264,750	762,551	44,448	30.00
31.00	03100	INTENSIVE CARE UNIT	34,492	41,518	64,456	205,279	12,152	31.00
43.00	04300	NURSERY	3,302	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,226	18,422	87,811	280,193	140,303	50.00
51.00	05100	RECOVERY ROOM	3,027	0	44,256	142,456	9,606	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,629	51,084	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,836	0	132,769	339,016	18,388	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	41,129	0	53,633	176,209	0	54.02
56.00	05600	RADIOISOTOPE	1,875	0	9,202	0	15,660	56.00
57.00	05700	CT SCAN	9,272	0	18,447	0	13,872	57.00
58.00	05800	MRI	12,298	0	13,584	0	3,789	58.00
60.00	06000	LABORATORY	22,362	0	142,190	0	139,225	60.00
65.00	06500	RESPIRATORY THERAPY	11,091	0	39,349	103,180	4,435	65.00
66.00	06600	PHYSICAL THERAPY	35,134	0	78,040	0	6,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,557	0	586	67.00
68.00	06800	SPEECH PATHOLOGY	367	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	183	0	29,051	52,719	705	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	99,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	263,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,971	0	47,499	121,596	13,280	90.00
91.00	09100	EMERGENCY	49,164	0	93,245	296,189	34,420	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)	567,715	387,272	1,295,657	2,479,388	820,534	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,294	0	2,014	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	480,209	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	43,268	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	7,672	0	11,612	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	1,098,864	387,272	1,311,563	2,479,388	822,548	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,022,507					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,232,938				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	109,959	9,131,715	0	9,131,715	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,665	2,556,956	0	2,556,956	31.00
43.00	04300	NURSERY	0	2,878	327,660	0	327,660	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	141,321	5,408,926	0	5,408,926	50.00
51.00	05100	RECOVERY ROOM	0	11,891	1,498,295	0	1,498,295	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,220	974,460	0	974,460	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,919	3,501,136	0	3,501,136	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	35,233	4,339,829	0	4,339,829	54.02
56.00	05600	RADIOISOTOPE	0	18,365	586,537	0	586,537	56.00
57.00	05700	CT SCAN	0	112,792	1,031,672	0	1,031,672	57.00
58.00	05800	MRI	0	32,652	709,692	0	709,692	58.00
60.00	06000	LABORATORY	0	143,225	5,466,549	0	5,466,549	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,880	1,250,282	0	1,250,282	65.00
66.00	06600	PHYSICAL THERAPY	0	16,388	3,262,496	0	3,262,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,283	261,531	0	261,531	67.00
68.00	06800	SPEECH PATHOLOGY	0	377	31,348	0	31,348	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,006	534,722	0	534,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,007	1,031,604	0	1,031,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,356	2,695,753	0	2,695,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,022,507	358,365	11,417,181	0	11,417,181	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,665	1,059,898	0	1,059,898	90.00
91.00	09100	EMERGENCY	0	65,491	4,063,069	0	4,063,069	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)	2,022,507	1,232,938	61,141,311	0	61,141,311	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	117,438	0	117,438	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,919,408	0	5,919,408	192.00
192.01	19201	WELLNESS CENTER	0	0	549,605	0	549,605	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	1,479,482	0	1,479,482	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	551,848	0	551,848	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,022,507	1,232,938	69,759,092	0	69,759,092	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,976	11,863	22,839	22,839	4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	0	205,134	221,700	426,834	1,967	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	331,243	357,993	689,236	1,504	5.02
7.00	00700	OPERATION OF PLANT	0	327,168	353,589	680,757	543	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,811	7,361	14,172	0	8.00
9.00	00900	HOUSEKEEPING	0	14,370	15,531	29,901	460	9.00
10.00	01000	DIETARY	0	39,479	42,667	82,146	15	10.00
11.00	01100	CAFETERIA	0	33,167	35,846	69,013	92	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,593	9,287	17,880	1,433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,815	24,658	47,473	166	14.00
15.00	01500	PHARMACY	0	22,429	24,241	46,670	870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,442	33,981	65,423	289	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	477,398	515,950	993,348	3,257	30.00
31.00	03100	INTENSIVE CARE UNIT	0	106,710	115,328	222,038	1,028	31.00
43.00	04300	NURSERY	0	10,216	11,041	21,257	162	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	198,698	214,744	413,442	1,404	50.00
51.00	05100	RECOVERY ROOM	0	9,365	10,121	19,486	714	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	39,070	42,225	81,295	407	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	147,993	159,945	307,938	1,698	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	127,244	137,520	264,764	883	54.02
56.00	05600	RADIOISOTOPE	0	5,800	6,269	12,069	163	56.00
57.00	05700	CT SCAN	0	28,684	31,000	59,684	272	57.00
58.00	05800	MRI	0	38,048	41,121	79,169	190	58.00
60.00	06000	LABORATORY	0	69,184	74,771	143,955	1,510	60.00
65.00	06500	RESPIRATORY THERAPY	0	34,314	37,085	71,399	517	65.00
66.00	06600	PHYSICAL THERAPY	0	108,697	117,474	226,171	728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,135	1,227	2,362	28	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,135	1,227	2,362	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	568	613	1,181	264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	42,089	45,488	87,577	609	90.00
91.00	09100	EMERGENCY	0	152,103	164,386	316,489	1,484	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	2,652,078	2,866,252	5,518,330	22,657	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,981	7,545	14,526	37	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,489,809	1,610,117	3,099,926	0	192.00
192.01	19201	WELLNESS CENTER	0	133,862	144,672	278,534	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	23,735	25,652	49,387	145	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	145,894	157,675	303,569	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,452,359	4,811,913	9,264,272	22,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	428,801					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	30,801	721,541				5.02
7.00	00700	OPERATION OF PLANT	21,939	42,276	745,515			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,390	4,605	1,419	22,586		8.00
9.00	00900	HOUSEKEEPING	6,153	11,857	2,994	0	51,365	9.00
10.00	01000	DIETARY	1,885	3,632	8,226	0	596	10.00
11.00	01100	CAFETERIA	7,185	13,845	6,911	0	501	11.00
13.00	01300	NURSING ADMINISTRATION	13,547	26,106	1,790	0	130	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,353	8,388	4,754	300	345	14.00
15.00	01500	PHARMACY	11,075	21,341	4,674	0	339	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,570	12,660	6,552	0	475	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,212	75,561	99,475	5,285	7,213	30.00
31.00	03100	INTENSIVE CARE UNIT	11,645	22,439	22,235	1,423	1,612	31.00
43.00	04300	NURSERY	1,763	3,398	2,129	0	154	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,972	48,120	41,403	3,456	3,002	50.00
51.00	05100	RECOVERY ROOM	7,253	13,976	1,951	0	141	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,630	8,921	8,141	2,439	590	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,210	29,309	30,837	4,880	2,236	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	22,130	42,643	26,514	0	1,923	54.02
56.00	05600	RADIOISOTOPE	3,040	5,857	1,209	0	88	56.00
57.00	05700	CT SCAN	4,807	9,263	5,977	0	433	57.00
58.00	05800	MRI	3,444	6,636	7,928	0	575	58.00
60.00	06000	LABORATORY	28,085	54,120	14,416	0	1,045	60.00
65.00	06500	RESPIRATORY THERAPY	5,840	11,254	7,150	0	518	65.00
66.00	06600	PHYSICAL THERAPY	16,924	32,613	22,649	1,550	1,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,436	2,768	237	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	167	322	237	0	17	68.00
69.00	06900	ELECTROCARDIOLOGY	2,462	4,744	118	0	9	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,104	9,835	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,564	26,138	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,321	98,873	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,537	8,742	8,770	407	653	90.00
91.00	09100	EMERGENCY	18,779	36,188	31,694	2,846	2,298	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)	392,223	696,430	370,390	22,586	26,535	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	588	1,134	1,455	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,547	0	310,431	0	22,448	192.00
192.01	19201	WELLNESS CENTER	2,055	3,960	27,893	0	2,023	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	8,148	15,701	4,946	0	359	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	2,240	4,316	30,400	0	0	194.03
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)	428,801	721,541	745,515	22,586	51,365	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	96,500					10.00
11.00	01100	CAFETERIA	0	97,547				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,107	66,993			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,372	0	67,151		14.00
15.00	01500	PHARMACY	0	3,063	0	0	88,032	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,311	0	84	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,835	19,690	20,609	3,629	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,346	4,794	5,546	992	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,590	6,531	7,570	11,454	0	50.00
51.00	05100	RECOVERY ROOM	0	3,292	3,849	784	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,729	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,875	9,159	1,501	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	3,989	4,761	0	0	54.02
56.00	05600	RADIOISOTOPE	0	684	0	1,278	0	56.00
57.00	05700	CT SCAN	0	1,372	0	1,132	0	57.00
58.00	05800	MRI	0	1,010	0	309	0	58.00
60.00	06000	LABORATORY	0	10,575	0	11,366	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,927	2,788	362	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,804	0	524	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	339	0	48	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,161	1,424	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,084	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,488	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	88,032	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,533	3,285	1,084	0	90.00
91.00	09100	EMERGENCY	0	6,935	8,002	2,810	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)	96,500	96,364	66,993	66,987	88,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	319	0	164	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	864	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	96,500	97,547	66,993	67,151	88,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,364					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,393	1,344,507	0	1,344,507		30.00
31.00	03100	INTENSIVE CARE UNIT	509	304,607	0	304,607		31.00
43.00	04300	NURSERY	220	29,083	0	29,083		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,787	576,731	0	576,731		50.00
51.00	05100	RECOVERY ROOM	908	52,354	0	52,354		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	551	119,703	0	119,703		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,513	415,156	0	415,156		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
54.02	05402	ONCOLOGY	2,689	370,296	0	370,296		54.02
56.00	05600	RADIOISOTOPE	1,402	25,790	0	25,790		56.00
57.00	05700	CT SCAN	8,609	91,549	0	91,549		57.00
58.00	05800	MRI	2,492	101,753	0	101,753		58.00
60.00	06000	LABORATORY	10,932	276,004	0	276,004		60.00
65.00	06500	RESPIRATORY THERAPY	2,052	104,807	0	104,807		65.00
66.00	06600	PHYSICAL THERAPY	1,251	309,856	0	309,856		66.00
67.00	06700	OCCUPATIONAL THERAPY	174	7,392	0	7,392		67.00
68.00	06800	SPEECH PATHOLOGY	29	3,134	0	3,134		68.00
69.00	06900	ELECTROCARDIOLOGY	1,374	13,795	0	13,795		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,596	25,619	0	25,619		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,386	64,576	0	64,576		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,608	265,834	0	265,834		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	890	120,087	0	120,087		90.00
91.00	09100	EMERGENCY	4,999	432,524	0	432,524		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)	94,364	5,055,157	0	5,055,157		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,223	0	18,223		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,456,352	0	3,456,352		192.00
192.01	19201	WELLNESS CENTER	0	314,465	0	314,465		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	79,550	0	79,550		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	340,525	0	340,525		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	94,364	9,264,272	0	9,264,272		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	392,246					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		392,246				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	967	967	22,878,886			4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL	18,072	18,072	1,970,807	-11,640,110	58,118,982	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	29,182	29,182	1,506,561	0	4,174,764	5.02
7.00	00700	OPERATION OF PLANT	28,823	28,823	543,694	0	2,973,544	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	600	600	0	0	323,917	8.00
9.00	00900	HOUSEKEEPING	1,266	1,266	460,527	0	833,980	9.00
10.00	01000	DIETARY	3,478	3,478	14,543	0	255,494	10.00
11.00	01100	CAFETERIA	2,922	2,922	92,303	0	973,843	11.00
13.00	01300	NURSING ADMINISTRATION	757	757	1,436,304	0	1,836,178	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,010	2,010	166,007	0	589,996	14.00
15.00	01500	PHARMACY	1,976	1,976	871,478	0	1,501,027	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	2,770	289,646	0	890,475	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,058	42,058	3,258,049	0	5,314,700	30.00
31.00	03100	INTENSIVE CARE UNIT	9,401	9,401	1,030,500	0	1,578,288	31.00
43.00	04300	NURSERY	900	900	162,445	0	238,990	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,505	17,505	1,406,568	0	3,384,592	50.00
51.00	05100	RECOVERY ROOM	825	825	715,131	0	983,015	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,442	3,442	407,497	0	627,482	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,038	13,038	1,701,862	0	2,061,516	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	11,210	11,210	884,572	0	2,999,394	54.02
56.00	05600	RADIOISOTOPE	511	511	163,357	0	411,984	56.00
57.00	05700	CT SCAN	2,527	2,527	272,718	0	651,512	57.00
58.00	05800	MRI	3,352	3,352	190,881	0	466,733	58.00
60.00	06000	LABORATORY	6,095	6,095	1,513,443	0	3,806,626	60.00
65.00	06500	RESPIRATORY THERAPY	3,023	3,023	517,965	0	791,602	65.00
66.00	06600	PHYSICAL THERAPY	9,576	9,576	729,601	0	2,293,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	100	28,342	0	194,671	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	0	0	22,616	68.00
69.00	06900	ELECTROCARDIOLOGY	50	50	264,648	0	333,673	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	691,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,838,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,956,301	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,708	3,708	610,415	0	614,883	90.00
91.00	09100	EMERGENCY	13,400	13,400	1,486,872	0	2,545,320	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)	233,644	233,644	22,696,736	-11,640,110	53,161,204	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	37,157	0	79,747	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,250	131,250	0	0	3,191,571	192.00
192.01	19201	WELLNESS CENTER	11,793	11,793	0	0	278,534	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,091	2,091	144,993	0	1,104,357	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	12,853	12,853	0	0	303,569	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,452,359	4,811,913	3,630,564		11,640,110	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.350935	12.267590	0.158686		0.200281	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			22,839		428,801	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000998		0.007378	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-5,010,890	60,917,420				5.02
7.00	00700	OPERATION OF PLANT	0	3,569,088	315,202			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	388,791	600	454,744		8.00
9.00	00900	HOUSEKEEPING	0	1,001,010	1,266	0	299,501	9.00
10.00	01000	DIETARY	0	306,665	3,478	0	3,478	10.00
11.00	01100	CAFETERIA	0	1,168,885	2,922	0	2,922	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,203,930	757	0	757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	708,161	2,010	6,035	2,010	14.00
15.00	01500	PHARMACY	0	1,801,654	1,976	0	1,976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,068,820	2,770	0	2,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,379,133	42,058	106,415	42,058	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,894,389	9,401	28,650	9,401	31.00
43.00	04300	NURSERY	0	286,855	900	0	900	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,062,461	17,505	69,579	17,505	50.00
51.00	05100	RECOVERY ROOM	0	1,179,894	825	0	825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	753,155	3,442	49,115	3,442	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,474,398	13,038	98,249	13,038	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	3,600,116	11,210	0	11,210	54.02
56.00	05600	RADIOISOTOPE	0	494,497	511	0	511	56.00
57.00	05700	CT SCAN	0	781,997	2,527	0	2,527	57.00
58.00	05800	MRI	0	560,211	3,352	0	3,352	58.00
60.00	06000	LABORATORY	0	4,569,021	6,095	0	6,095	60.00
65.00	06500	RESPIRATORY THERAPY	0	950,145	3,023	0	3,023	65.00
66.00	06600	PHYSICAL THERAPY	0	2,753,297	9,576	31,214	9,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	233,660	100	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,146	100	0	100	68.00
69.00	06900	ELECTROCARDIOLOGY	0	400,501	50	0	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	830,274	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,206,690	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,349,500	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	738,032	3,708	8,186	3,808	90.00
91.00	09100	EMERGENCY	0	3,055,099	13,400	57,301	13,400	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)	-5,010,890	58,797,475	156,600	454,744	154,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	95,719	615	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-3,830,782	0	131,250	0	130,883	192.00
192.01	19201	WELLNESS CENTER	0	334,319	11,793	0	11,793	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,325,539	2,091	0	2,091	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	364,368	12,853	0	0	194.03
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)		5,010,890	3,862,670	428,125	1,098,864	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.082257	12.254586	0.941464	3.668983	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		721,541	745,515	22,586	51,365	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.011845	2.365198	0.049668	0.171502	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	35,464					10.00
11.00	01100	CAFETERIA	0	29,932				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,874	12,446,524			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	421	0	5,745,769		14.00
15.00	01500	PHARMACY	0	940	0	0	7,120,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	709	0	7,161	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,297	6,042	3,827,991	310,483	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,802	1,471	1,030,500	84,887	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,687	2,004	1,406,568	980,062	0	50.00
51.00	05100	RECOVERY ROOM	0	1,010	715,131	67,099	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,678	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,030	1,701,862	128,448	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	1,224	884,572	0	0	54.02
56.00	05600	RADIOISOTOPE	0	210	0	109,391	0	56.00
57.00	05700	CT SCAN	0	421	0	96,901	0	57.00
58.00	05800	MRI	0	310	0	26,464	0	58.00
60.00	06000	LABORATORY	0	3,245	0	972,536	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	898	517,965	30,979	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,781	0	44,863	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104	0	4,096	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	663	264,648	4,923	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	691,734	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,838,478	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,120,401	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,084	610,415	92,764	0	90.00
91.00	09100	EMERGENCY	0	2,128	1,486,872	240,435	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)	35,464	29,569	12,446,524	5,731,704	7,120,401	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	98	0	14,065	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	265	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	387,272	1,311,563	2,479,388	822,548	2,022,507	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.920144	43.818088	0.199203	0.143157	0.284044	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	96,500	97,547	66,993	67,151	88,032	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.721069	3.258954	0.005382	0.011687	0.012363	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2018 2:39 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL			5.02
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	528,774,443		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	47,152,048		30.00
31.00	03100	INTENSIVE CARE UNIT	2,858,102		31.00
43.00	04300	NURSERY	1,234,252		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	60,600,725		50.00
51.00	05100	RECOVERY ROOM	5,099,074		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,096,149		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,116,058		54.00
54.01	05401	ULTRASOUND	0		54.01
54.02	05402	ONCOLOGY	15,108,470		54.02
56.00	05600	RADIOISOTOPE	7,875,405		56.00
57.00	05700	CT SCAN	48,366,926		57.00
58.00	05800	MRI	14,001,796		58.00
60.00	06000	LABORATORY	61,417,249		60.00
65.00	06500	RESPIRATORY THERAPY	11,526,553		65.00
66.00	06600	PHYSICAL THERAPY	7,027,622		66.00
67.00	06700	OCCUPATIONAL THERAPY	979,068		67.00
68.00	06800	SPEECH PATHOLOGY	161,792		68.00
69.00	06900	ELECTROCARDIOLOGY	7,721,168		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,582,604		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,020,669		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153,743,104		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		76.00
76.01	03610	SLEEP LAB	0		76.01
76.03	03951	WOUND CARE	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	5,002,012		90.00
91.00	09100	EMERGENCY	28,083,597		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)	528,774,443		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01	19201	WELLNESS CENTER	0		192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		194.00
194.01	07951	MARKETING	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0		194.03
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)	1,232,938		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002332		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	94,364		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000178		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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,131,715		9,131,715	0	9,131,715	30.00
31.00	03100	INTENSIVE CARE UNIT	2,556,956		2,556,956	0	2,556,956	31.00
43.00	04300	NURSERY	327,660		327,660	0	327,660	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,408,926		5,408,926	0	5,408,926	50.00
51.00	05100	RECOVERY ROOM	1,498,295		1,498,295	0	1,498,295	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	974,460		974,460	0	974,460	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,501,136		3,501,136	0	3,501,136	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	4,339,829		4,339,829	0	4,339,829	54.02
56.00	05600	RADIOISOTOPE	586,537		586,537	0	586,537	56.00
57.00	05700	CT SCAN	1,031,672		1,031,672	0	1,031,672	57.00
58.00	05800	MRI	709,692		709,692	0	709,692	58.00
60.00	06000	LABORATORY	5,466,549		5,466,549	0	5,466,549	60.00
65.00	06500	RESPIRATORY THERAPY	1,250,282	0	1,250,282	0	1,250,282	65.00
66.00	06600	PHYSICAL THERAPY	3,262,496	0	3,262,496	0	3,262,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,531	0	261,531	0	261,531	67.00
68.00	06800	SPEECH PATHOLOGY	31,348	0	31,348	0	31,348	68.00
69.00	06900	ELECTROCARDIOLOGY	534,722		534,722	0	534,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,031,604		1,031,604	0	1,031,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,695,753		2,695,753	0	2,695,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,417,181		11,417,181	0	11,417,181	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,059,898		1,059,898	0	1,059,898	90.00
91.00	09100	EMERGENCY	4,063,069		4,063,069	0	4,063,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,079,885		2,079,885		2,079,885	92.00
200.00		Subtotal (see instructions)	63,221,196	0	63,221,196	0	63,221,196	200.00
201.00		Less Observation Beds	2,079,885		2,079,885		2,079,885	201.00
202.00		Total (see instructions)	61,141,311	0	61,141,311	0	61,141,311	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,805,164		19,805,164			30.00
31.00	03100	INTENSIVE CARE UNIT	2,858,102		2,858,102			31.00
43.00	04300	NURSERY	1,234,252		1,234,252			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,068,178	40,532,547	60,600,725	0.089255	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,786,883	3,312,191	5,099,074	0.293837	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,838,770	257,379	3,096,149	0.314733	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,180	12,455,878	14,116,058	0.248025	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	28,601	15,079,869	15,108,470	0.287245	0.000000	54.02
56.00	05600	RADIOISOTOPE	371,335	7,504,070	7,875,405	0.074477	0.000000	56.00
57.00	05700	CT SCAN	7,123,338	41,243,588	48,366,926	0.021330	0.000000	57.00
58.00	05800	MRI	841,295	13,160,501	14,001,796	0.050686	0.000000	58.00
60.00	06000	LABORATORY	14,288,760	47,128,489	61,417,249	0.089007	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,410,218	4,116,335	11,526,553	0.108470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,213,419	5,814,203	7,027,622	0.464239	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,612	879,456	979,068	0.267122	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	65,857	95,935	161,792	0.193755	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,505,468	6,215,700	7,721,168	0.069254	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,844,477	8,738,127	14,582,604	0.070742	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,155,122	5,865,547	19,020,669	0.141728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,126,079	108,617,025	153,743,104	0.074261	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	550,943	4,451,069	5,002,012	0.211894	0.000000	90.00
91.00	09100	EMERGENCY	5,184,737	22,898,860	28,083,597	0.144678	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,754,137	25,592,747	27,346,884	0.076056	0.000000	92.00
200.00		Subtotal (see instructions)	154,814,927	373,959,516	528,774,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	154,814,927	373,959,516	528,774,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.089255	50.00
51.00	05100	RECOVERY ROOM	0.293837	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314733	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248025	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.287245	54.02
56.00	05600	RADIOISOTOPE	0.074477	56.00
57.00	05700	CT SCAN	0.021330	57.00
58.00	05800	MRI	0.050686	58.00
60.00	06000	LABORATORY	0.089007	60.00
65.00	06500	RESPIRATORY THERAPY	0.108470	65.00
66.00	06600	PHYSICAL THERAPY	0.464239	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267122	67.00
68.00	06800	SPEECH PATHOLOGY	0.193755	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.070742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.074261	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.211894	90.00
91.00	09100	EMERGENCY	0.144678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076056	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,131,715		9,131,715	0	9,131,715	30.00
31.00	03100	INTENSIVE CARE UNIT	2,556,956		2,556,956	0	2,556,956	31.00
43.00	04300	NURSERY	327,660		327,660	0	327,660	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,408,926		5,408,926	0	5,408,926	50.00
51.00	05100	RECOVERY ROOM	1,498,295		1,498,295	0	1,498,295	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	974,460		974,460	0	974,460	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,501,136		3,501,136	0	3,501,136	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	4,339,829		4,339,829	0	4,339,829	54.02
56.00	05600	RADIOISOTOPE	586,537		586,537	0	586,537	56.00
57.00	05700	CT SCAN	1,031,672		1,031,672	0	1,031,672	57.00
58.00	05800	MRI	709,692		709,692	0	709,692	58.00
60.00	06000	LABORATORY	5,466,549		5,466,549	0	5,466,549	60.00
65.00	06500	RESPIRATORY THERAPY	1,250,282	0	1,250,282	0	1,250,282	65.00
66.00	06600	PHYSICAL THERAPY	3,262,496	0	3,262,496	0	3,262,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,531	0	261,531	0	261,531	67.00
68.00	06800	SPEECH PATHOLOGY	31,348	0	31,348	0	31,348	68.00
69.00	06900	ELECTROCARDIOLOGY	534,722		534,722	0	534,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,031,604		1,031,604	0	1,031,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,695,753		2,695,753	0	2,695,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,417,181		11,417,181	0	11,417,181	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,059,898		1,059,898	0	1,059,898	90.00
91.00	09100	EMERGENCY	4,063,069		4,063,069	0	4,063,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,079,885		2,079,885		2,079,885	92.00
200.00		Subtotal (see instructions)	63,221,196	0	63,221,196	0	63,221,196	200.00
201.00		Less Observation Beds	2,079,885		2,079,885		2,079,885	201.00
202.00		Total (see instructions)	61,141,311	0	61,141,311	0	61,141,311	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,805,164		19,805,164			30.00
31.00	03100	INTENSIVE CARE UNIT	2,858,102		2,858,102			31.00
43.00	04300	NURSERY	1,234,252		1,234,252			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,068,178	40,532,547	60,600,725	0.089255	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,786,883	3,312,191	5,099,074	0.293837	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,838,770	257,379	3,096,149	0.314733	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,180	12,455,878	14,116,058	0.248025	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	28,601	15,079,869	15,108,470	0.287245	0.000000	54.02
56.00	05600	RADIOISOTOPE	371,335	7,504,070	7,875,405	0.074477	0.000000	56.00
57.00	05700	CT SCAN	7,123,338	41,243,588	48,366,926	0.021330	0.000000	57.00
58.00	05800	MRI	841,295	13,160,501	14,001,796	0.050686	0.000000	58.00
60.00	06000	LABORATORY	14,288,760	47,128,489	61,417,249	0.089007	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,410,218	4,116,335	11,526,553	0.108470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,213,419	5,814,203	7,027,622	0.464239	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,612	879,456	979,068	0.267122	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	65,857	95,935	161,792	0.193755	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,505,468	6,215,700	7,721,168	0.069254	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,844,477	8,738,127	14,582,604	0.070742	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,155,122	5,865,547	19,020,669	0.141728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,126,079	108,617,025	153,743,104	0.074261	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	550,943	4,451,069	5,002,012	0.211894	0.000000	90.00
91.00	09100	EMERGENCY	5,184,737	22,898,860	28,083,597	0.144678	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,754,137	25,592,747	27,346,884	0.076056	0.000000	92.00
200.00		Subtotal (see instructions)	154,814,927	373,959,516	528,774,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	154,814,927	373,959,516	528,774,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.089255	50.00
51.00	05100	RECOVERY ROOM	0.293837	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314733	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248025	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.287245	54.02
56.00	05600	RADIOISOTOPE	0.074477	56.00
57.00	05700	CT SCAN	0.021330	57.00
58.00	05800	MRI	0.050686	58.00
60.00	06000	LABORATORY	0.089007	60.00
65.00	06500	RESPIRATORY THERAPY	0.108470	65.00
66.00	06600	PHYSICAL THERAPY	0.464239	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267122	67.00
68.00	06800	SPEECH PATHOLOGY	0.193755	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.070742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.074261	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.211894	90.00
91.00	09100	EMERGENCY	0.144678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076056	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part II Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,408,926	576,731	4,832,195	0	0	50.00
51.00	05100	RECOVERY ROOM	1,498,295	52,354	1,445,941	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	974,460	119,703	854,757	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,501,136	415,156	3,085,980	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	4,339,829	370,296	3,969,533	0	0	54.02
56.00	05600	RADIOISOTOPE	586,537	25,790	560,747	0	0	56.00
57.00	05700	CT SCAN	1,031,672	91,549	940,123	0	0	57.00
58.00	05800	MRI	709,692	101,753	607,939	0	0	58.00
60.00	06000	LABORATORY	5,466,549	276,004	5,190,545	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,250,282	104,807	1,145,475	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,262,496	309,856	2,952,640	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,531	7,392	254,139	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,348	3,134	28,214	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	534,722	13,795	520,927	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,031,604	25,619	1,005,985	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,695,753	64,576	2,631,177	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,417,181	265,834	11,151,347	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,059,898	120,087	939,811	0	0	90.00
91.00	09100	EMERGENCY	4,063,069	432,524	3,630,545	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,079,885	306,232	1,773,653	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	51,204,865	3,683,192	47,521,673	0	0	200.00
201.00		Less Observation Beds	2,079,885	306,232	1,773,653	0	0	201.00
202.00		Total (line 200 minus line 201)	49,124,980	3,376,960	45,748,020	0	0	202.00

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

Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part II Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,408,926	60,600,725	0.089255		50.00
51.00	05100	RECOVERY ROOM	1,498,295	5,099,074	0.293837		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	974,460	3,096,149	0.314733		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,501,136	14,116,058	0.248025		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
54.02	05402	ONCOLOGY	4,339,829	15,108,470	0.287245		54.02
56.00	05600	RADIOISOTOPE	586,537	7,875,405	0.074477		56.00
57.00	05700	CT SCAN	1,031,672	48,366,926	0.021330		57.00
58.00	05800	MRI	709,692	14,001,796	0.050686		58.00
60.00	06000	LABORATORY	5,466,549	61,417,249	0.089007		60.00
65.00	06500	RESPIRATORY THERAPY	1,250,282	11,526,553	0.108470		65.00
66.00	06600	PHYSICAL THERAPY	3,262,496	7,027,622	0.464239		66.00
67.00	06700	OCCUPATIONAL THERAPY	261,531	979,068	0.267122		67.00
68.00	06800	SPEECH PATHOLOGY	31,348	161,792	0.193755		68.00
69.00	06900	ELECTROCARDIOLOGY	534,722	7,721,168	0.069254		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,031,604	14,582,604	0.070742		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,695,753	19,020,669	0.141728		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,417,181	153,743,104	0.074261		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	0	0	0.000000		76.01
76.03	03951	WOUND CARE	0	0	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,059,898	5,002,012	0.211894		90.00
91.00	09100	EMERGENCY	4,063,069	28,083,597	0.144678		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,079,885	27,346,884	0.076056		92.00
200.00		Subtotal (sum of lines 50 thru 199)	51,204,865	504,876,925			200.00
201.00		Less Observation Beds	2,079,885	0			201.00
202.00		Total (line 200 minus line 201)	49,124,980	504,876,925			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title V | 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	9,131,715		9,131,715	0	9,131,715	30.00
31.00	03100	INTENSIVE CARE UNIT	2,556,956		2,556,956	0	2,556,956	31.00
43.00	04300	NURSERY	327,660		327,660	0	327,660	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,408,926		5,408,926	0	5,408,926	50.00
51.00	05100	RECOVERY ROOM	1,498,295		1,498,295	0	1,498,295	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	974,460		974,460	0	974,460	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,501,136		3,501,136	0	3,501,136	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	4,339,829		4,339,829	0	4,339,829	54.02
56.00	05600	RADIOISOTOPE	586,537		586,537	0	586,537	56.00
57.00	05700	CT SCAN	1,031,672		1,031,672	0	1,031,672	57.00
58.00	05800	MRI	709,692		709,692	0	709,692	58.00
60.00	06000	LABORATORY	5,466,549		5,466,549	0	5,466,549	60.00
65.00	06500	RESPIRATORY THERAPY	1,250,282	0	1,250,282	0	1,250,282	65.00
66.00	06600	PHYSICAL THERAPY	3,262,496	0	3,262,496	0	3,262,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,531	0	261,531	0	261,531	67.00
68.00	06800	SPEECH PATHOLOGY	31,348	0	31,348	0	31,348	68.00
69.00	06900	ELECTROCARDIOLOGY	534,722		534,722	0	534,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,031,604		1,031,604	0	1,031,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,695,753		2,695,753	0	2,695,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,417,181		11,417,181	0	11,417,181	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,059,898		1,059,898	0	1,059,898	90.00
91.00	09100	EMERGENCY	4,063,069		4,063,069	0	4,063,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,079,885		2,079,885		2,079,885	92.00
200.00		Subtotal (see instructions)	63,221,196	0	63,221,196	0	63,221,196	200.00
201.00		Less Observation Beds	2,079,885		2,079,885		2,079,885	201.00
202.00		Total (see instructions)	61,141,311	0	61,141,311	0	61,141,311	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title V | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,805,164		19,805,164			30.00
31.00	03100	INTENSIVE CARE UNIT	2,858,102		2,858,102			31.00
43.00	04300	NURSERY	1,234,252		1,234,252			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,068,178	40,532,547	60,600,725	0.089255	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,786,883	3,312,191	5,099,074	0.293837	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,838,770	257,379	3,096,149	0.314733	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,180	12,455,878	14,116,058	0.248025	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	28,601	15,079,869	15,108,470	0.287245	0.000000	54.02
56.00	05600	RADIOISOTOPE	371,335	7,504,070	7,875,405	0.074477	0.000000	56.00
57.00	05700	CT SCAN	7,123,338	41,243,588	48,366,926	0.021330	0.000000	57.00
58.00	05800	MRI	841,295	13,160,501	14,001,796	0.050686	0.000000	58.00
60.00	06000	LABORATORY	14,288,760	47,128,489	61,417,249	0.089007	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,410,218	4,116,335	11,526,553	0.108470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,213,419	5,814,203	7,027,622	0.464239	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,612	879,456	979,068	0.267122	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	65,857	95,935	161,792	0.193755	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,505,468	6,215,700	7,721,168	0.069254	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,844,477	8,738,127	14,582,604	0.070742	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,155,122	5,865,547	19,020,669	0.141728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,126,079	108,617,025	153,743,104	0.074261	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	550,943	4,451,069	5,002,012	0.211894	0.000000	90.00
91.00	09100	EMERGENCY	5,184,737	22,898,860	28,083,597	0.144678	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,754,137	25,592,747	27,346,884	0.076056	0.000000	92.00
200.00		Subtotal (see instructions)	154,814,927	373,959,516	528,774,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	154,814,927	373,959,516	528,774,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title V | 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.000000	54.02
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,344,507	0	1,344,507	10,265	130.98	30.00
31.00	INTENSIVE CARE UNIT	304,607		304,607	1,272	239.47	31.00
43.00	NURSERY	29,083		29,083	951	30.58	43.00
200.00	Total (lines 30 through 199)	1,678,197		1,678,197	12,488		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,966	388,487	30.00
31.00	INTENSIVE CARE UNIT	483	115,664	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	3,449	504,151	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part II Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	576,731	60,600,725	0.009517	5,280,694	50,256	50.00
51.00	05100	RECOVERY ROOM	52,354	5,099,074	0.010267	440,797	4,526	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,703	3,096,149	0.038662	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,156	14,116,058	0.029410	1,605,292	47,212	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	370,296	15,108,470	0.024509	9,270	227	54.02
56.00	05600	RADIOISOTOPE	25,790	7,875,405	0.003275	215,828	707	56.00
57.00	05700	CT SCAN	91,549	48,366,926	0.001893	4,025,101	7,620	57.00
58.00	05800	MRI	101,753	14,001,796	0.007267	405,192	2,945	58.00
60.00	06000	LABORATORY	276,004	61,417,249	0.004494	6,132,707	27,560	60.00
65.00	06500	RESPIRATORY THERAPY	104,807	11,526,553	0.009093	3,363,636	30,586	65.00
66.00	06600	PHYSICAL THERAPY	309,856	7,027,622	0.044091	486,775	21,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,392	979,068	0.007550	45,181	341	67.00
68.00	06800	SPEECH PATHOLOGY	3,134	161,792	0.019371	43,973	852	68.00
69.00	06900	ELECTROCARDIOLOGY	13,795	7,721,168	0.001787	1,494,888	2,671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,619	14,582,604	0.001757	1,849,339	3,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,576	19,020,669	0.003395	3,785,013	12,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	265,834	153,743,104	0.001729	17,662,882	30,539	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,087	5,002,012	0.024008	159,202	3,822	90.00
91.00	09100	EMERGENCY	432,524	28,083,597	0.015401	1,705,743	26,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	306,232	27,346,884	0.011198	834,222	9,342	92.00
200.00		Total (lines 50 through 199)	3,683,192	504,876,925		49,545,735	283,037	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part III Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,265	0.00	2,966	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,272	0.00	483	31.00
43.00	04300	NURSERY		0	951	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	12,488		3,449	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	0		43.00
200.00		Total (lines 30 through 199)	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	60,600,725	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,099,074	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,096,149	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,116,058	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	0	0	0	15,108,470	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	7,875,405	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	48,366,926	0.000000	57.00
58.00	05800	MRI	0	0	0	14,001,796	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	61,417,249	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,526,553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,027,622	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	979,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	161,792	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,721,168	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,582,604	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,020,669	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	153,743,104	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,002,012	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	28,083,597	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	27,346,884	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	504,876,925		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2018 2:39 pm

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		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	5,280,694	0	5,954,381	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	440,797	0	426,808	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,605,292	0	4,094,946	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.000000	9,270	0	4,675,930	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	215,828	0	2,156,864	0	56.00
57.00	05700	CT SCAN	0.000000	4,025,101	0	8,749,991	0	57.00
58.00	05800	MRI	0.000000	405,192	0	2,476,385	0	58.00
60.00	06000	LABORATORY	0.000000	6,132,707	0	4,236,671	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,363,636	0	769,799	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	486,775	0	35,954	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	45,181	0	3,455	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	43,973	0	3,663	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,494,888	0	3,610,780	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,849,339	0	1,161,815	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,785,013	0	708,900	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	17,662,882	0	31,768,089	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	159,202	0	828,126	0	90.00
91.00	09100	EMERGENCY	0.000000	1,705,743	0	3,372,694	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	834,222	0	1,281,365	0	92.00
200.00		Total (lines 50 through 199)		49,545,735	0	76,316,616	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.089255	5,954,381	0	0	531,458	50.00
51.00	05100	RECOVERY ROOM	0.293837	426,808	0	0	125,412	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314733	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248025	4,094,946	0	0	1,015,649	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.287245	4,675,930	0	0	1,343,138	54.02
56.00	05600	RADIOISOTOPE	0.074477	2,156,864	0	0	160,637	56.00
57.00	05700	CT SCAN	0.021330	8,749,991	0	0	186,637	57.00
58.00	05800	MRI	0.050686	2,476,385	0	0	125,518	58.00
60.00	06000	LABORATORY	0.089007	4,236,671	0	0	377,093	60.00
65.00	06500	RESPIRATORY THERAPY	0.108470	769,799	1,668	0	83,500	65.00
66.00	06600	PHYSICAL THERAPY	0.464239	35,954	0	0	16,691	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267122	3,455	0	0	923	67.00
68.00	06800	SPEECH PATHOLOGY	0.193755	3,663	0	0	710	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069254	3,610,780	0	0	250,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.070742	1,161,815	0	0	82,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141728	708,900	0	0	100,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.074261	31,768,089	33,770	0	2,359,130	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.211894	828,126	0	0	175,475	90.00
91.00	09100	EMERGENCY	0.144678	3,372,694	0	0	487,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076056	1,281,365	0	0	97,455	92.00
200.00		Subtotal (see instructions)		76,316,616	35,438	0	7,520,102	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		76,316,616	35,438	0	7,520,102	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	05402	ONCOLOGY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	181	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 PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,508	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	2,689	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,689	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part I Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,344,507	0	1,344,507	10,265	130.98	30.00
31.00	INTENSIVE CARE UNIT	304,607		304,607	1,272	239.47	31.00
43.00	NURSERY	29,083		29,083	951	30.58	43.00
200.00	Total (lines 30 through 199)	1,678,197		1,678,197	12,488		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,046	137,005				30.00
31.00	INTENSIVE CARE UNIT	204	48,852				31.00
43.00	NURSERY	463	14,159				43.00
200.00	Total (lines 30 through 199)	1,713	200,016				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part II Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	576,731	60,600,725	0.009517	398,971	3,797	50.00
51.00	05100	RECOVERY ROOM	52,354	5,099,074	0.010267	28,544	293	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,703	3,096,149	0.038662	86,559	3,347	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,156	14,116,058	0.029410	54,888	1,614	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	370,296	15,108,470	0.024509	0	0	54.02
56.00	05600	RADIOISOTOPE	25,790	7,875,405	0.003275	3,335	11	56.00
57.00	05700	CT SCAN	91,549	48,366,926	0.001893	82,466	156	57.00
58.00	05800	MRI	101,753	14,001,796	0.007267	0	0	58.00
60.00	06000	LABORATORY	276,004	61,417,249	0.004494	214,261	963	60.00
65.00	06500	RESPIRATORY THERAPY	104,807	11,526,553	0.009093	112,538	1,023	65.00
66.00	06600	PHYSICAL THERAPY	309,856	7,027,622	0.044091	19,272	850	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,392	979,068	0.007550	1,132	9	67.00
68.00	06800	SPEECH PATHOLOGY	3,134	161,792	0.019371	837	16	68.00
69.00	06900	ELECTROCARDIOLOGY	13,795	7,721,168	0.001787	10,580	19	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,619	14,582,604	0.001757	206,642	363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,576	19,020,669	0.003395	58,377	198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	265,834	153,743,104	0.001729	763,229	1,320	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120,087	5,002,012	0.024008	2,569	62	90.00
91.00	09100	EMERGENCY	432,524	28,083,597	0.015401	59,918	923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	306,232	27,346,884	0.011198	8,321	93	92.00
200.00		Total (lines 50 through 199)	3,683,192	504,876,925		2,112,439	15,057	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part III Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,265	0.00	1,046	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,272	0.00	204	31.00
43.00	04300	NURSERY		0	951	0.00	463	43.00
200.00		Total (lines 30 through 199)		0	12,488		1,713	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	60,600,725	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,099,074	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,096,149	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,116,058	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	0	0	0	15,108,470	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	7,875,405	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	48,366,926	0.000000	57.00
58.00	05800	MRI	0	0	0	14,001,796	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	61,417,249	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,526,553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,027,622	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	979,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	161,792	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,721,168	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,582,604	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,020,669	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	153,743,104	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,002,012	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	28,083,597	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	27,346,884	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	504,876,925		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	398,971	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	28,544	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	86,559	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54,888	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	3,335	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	82,466	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	214,261	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	112,538	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,272	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,132	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	837	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,580	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	206,642	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	58,377	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	763,229	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	2,569	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	59,918	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	8,321	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,112,439	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.089255	0	0	222,516	0	50.00
51.00	05100	RECOVERY ROOM	0.293837	0	0	22,514	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314733	0	0	7,275	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248025	0	0	221,313	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.287245	0	0	234,661	0	54.02
56.00	05600	RADIOISOTOPE	0.074477	0	0	10,117	0	56.00
57.00	05700	CT SCAN	0.021330	0	0	367,283	0	57.00
58.00	05800	MRI	0.050686	0	0	99,385	0	58.00
60.00	06000	LABORATORY	0.089007	0	0	531,947	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.108470	0	0	27,605	0	65.00
66.00	06600	PHYSICAL THERAPY	0.464239	0	0	23,089	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267122	0	0	7,495	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.193755	0	0	419	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069254	0	0	33,831	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.070742	0	0	76,921	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141728	0	0	10,932	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.074261	0	0	432,780	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.211894	0	0	20,871	0	90.00
91.00	09100	EMERGENCY	0.144678	0	0	413,835	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076056	0	0	87,038	0	92.00
200.00		Subtotal (see instructions)		0	0	2,851,827	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	2,851,827	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	19,861		50.00
51.00	05100	RECOVERY ROOM	0	6,615		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,290		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,891		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	05402	ONCOLOGY	0	67,405		54.02
56.00	05600	RADIOISOTOPE	0	753		56.00
57.00	05700	CT SCAN	0	7,834		57.00
58.00	05800	MRI	0	5,037		58.00
60.00	06000	LABORATORY	0	47,347		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,994		65.00
66.00	06600	PHYSICAL THERAPY	0	10,719		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,002		67.00
68.00	06800	SPEECH PATHOLOGY	0	81		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,343		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,442		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,549		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,139		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,422		90.00
91.00	09100	EMERGENCY	0	59,873		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,620		92.00
200.00		Subtotal (see instructions)	0	340,217		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	340,217		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,265	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,265	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)	7,927	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,966	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,131,715	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,131,715	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)	9,131,715	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)	889.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,638,554	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,638,554	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,556,956	1,272	2,010.19	483	970,922	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,707,833	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,317,309	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)	504,151	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	283,037	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	787,188	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,530,121	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)	2,338	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	889.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,079,885	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,344,507	9,131,715	0.147235	2,079,885	306,232	90.00
91.00	Nursing School cost	0	9,131,715	0.000000	2,079,885	0	91.00
92.00	Allied health cost	0	9,131,715	0.000000	2,079,885	0	92.00
93.00	All other Medical Education	0	9,131,715	0.000000	2,079,885	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,265	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,265	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)	7,927	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,046	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)	951	15.00
16.00	Nursery days (title V or XIX only)	463	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,131,715	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,131,715	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)	9,131,715	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)	889.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	930,522	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)	930,522	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2018 2:39 pm

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	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)	327,660	951	344.54	463	159,522	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,556,956	1,272	2,010.19	204	410,079	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)	217,699	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,717,822	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	200,016	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	15,057	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	215,073	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,502,749	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)	2,338	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	889.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,079,885	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,344,507	9,131,715	0.147235	2,079,885	306,232	90.00
91.00	Nursing School cost	0	9,131,715	0.000000	2,079,885	0	91.00
92.00	Allied health cost	0	9,131,715	0.000000	2,079,885	0	92.00
93.00	All other Medical Education	0	9,131,715	0.000000	2,079,885	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-3 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,501,806		30.00
31.00	03100	INTENSIVE CARE UNIT		1,875,923		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.089255	5,280,694	471,328	50.00
51.00	05100	RECOVERY ROOM	0.293837	440,797	129,522	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314733	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248025	1,605,292	398,153	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.287245	9,270	2,663	54.02
56.00	05600	RADIOISOTOPE	0.074477	215,828	16,074	56.00
57.00	05700	CT SCAN	0.021330	4,025,101	85,855	57.00
58.00	05800	MRI	0.050686	405,192	20,538	58.00
60.00	06000	LABORATORY	0.089007	6,132,707	545,854	60.00
65.00	06500	RESPIRATORY THERAPY	0.108470	3,363,636	364,854	65.00
66.00	06600	PHYSICAL THERAPY	0.464239	486,775	225,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267122	45,181	12,069	67.00
68.00	06800	SPEECH PATHOLOGY	0.193755	43,973	8,520	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069254	1,494,888	103,527	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.070742	1,849,339	130,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141728	3,785,013	536,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.074261	17,662,882	1,311,663	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.211894	159,202	33,734	90.00
91.00	09100	EMERGENCY	0.144678	1,705,743	246,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076056	834,222	63,448	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,545,735	4,707,833	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)		49,545,735		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-3 | Date/Time Prepared: 7/31/2018 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		326,542		30.00
31.00	03100	INTENSIVE CARE UNIT		99,589		31.00
43.00	04300	NURSERY		64,645		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.089255	398,971	35,610	50.00
51.00	05100	RECOVERY ROOM	0.293837	28,544	8,387	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314733	86,559	27,243	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248025	54,888	13,614	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.287245	0	0	54.02
56.00	05600	RADIOISOTOPE	0.074477	3,335	248	56.00
57.00	05700	CT SCAN	0.021330	82,466	1,759	57.00
58.00	05800	MRI	0.050686	0	0	58.00
60.00	06000	LABORATORY	0.089007	214,261	19,071	60.00
65.00	06500	RESPIRATORY THERAPY	0.108470	112,538	12,207	65.00
66.00	06600	PHYSICAL THERAPY	0.464239	19,272	8,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267122	1,132	302	67.00
68.00	06800	SPEECH PATHOLOGY	0.193755	837	162	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069254	10,580	733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.070742	206,642	14,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.141728	58,377	8,274	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.074261	763,229	56,678	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.211894	2,569	544	90.00
91.00	09100	EMERGENCY	0.144678	59,918	8,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076056	8,321	633	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,112,439	217,699	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)		2,112,439		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet E Part A Date/Time Prepared: 7/31/2018 2:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,689,326	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,635,233	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	30,322	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	65.59	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.64	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.76	31.00
32.00	Sum of lines 30 and 31	20.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.05	33.00
34.00	Disproportionate share adjustment (see instructions)	95,659	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet E Part A Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	0	35.00
35.01	Factor 3 (see instructions)	0.000068328	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	408,429	697,909	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	239,462	288,724	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	528,186		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,978,726		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,978,726	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		512,604	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		7,491,330	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,491,330	61.00
62.00	Deductibles billed to program beneficiaries		896,132	62.00
63.00	Coinsurance billed to program beneficiaries		10,528	63.00
64.00	Allowable bad debts (see instructions)		76,905	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		49,988	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,242	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,634,658	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-28,626	70.93
70.94	HRR adjustment amount (see instructions)		-11,857	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet E Part A Date/Time Prepared: 7/31/2018 2:39 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,594,175	71.00
71.01	Sequestration adjustment (see instructions)		131,884	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,352,184	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		110,107	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		929,618	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet E Part B Date/Time Prepared: 7/31/2018 2:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,689	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,520,102	2.00
3.00	OPPS payments	7,108,912	3.00
4.00	Outlier payment (see instructions)	28,317	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)	2,689	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	35,438	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)	35,438	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)	35,438	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	32,749	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)	2,689	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)	7,137,229	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	5,262	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,398,124	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,736,532	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,736,532	30.00
31.00	Primary payer payments	2,722	31.00
32.00	Subtotal (line 30 minus line 31)	5,733,810	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)	228,390	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	148,454	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	184,140	36.00
37.00	Subtotal (see instructions)	5,882,264	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-6	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,882,270	40.00
40.01	Sequestration adjustment (see instructions)	117,645	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,708,521	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	56,104	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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet E-1 Part I | Date/Time Prepared: 7/31/2018 2:39 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,316,104		5,617,288	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		36,080		91,233	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)		6,352,184		5,708,521	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		110,107		56,104	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,462,291		5,764,625	7.00

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G | Date/Time Prepared: 7/31/2018 2:39 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	-555,156	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	29,918,052	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,173,650	0	0	0	6.00
7.00	Inventory	1,708,469	0	0	0	7.00
8.00	Prepaid expenses	1,000,319	0	0	0	8.00
9.00	Other current assets	107,326	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)	24,005,360	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,360,405	0	0	0	12.00
13.00	Land improvements	1,058,635	0	0	0	13.00
14.00	Accumulated depreciation	-759,642	0	0	0	14.00
15.00	Buildings	25,520,788	0	0	0	15.00
16.00	Accumulated depreciation	-7,776,820	0	0	0	16.00
17.00	Leasehold improvements	19,637,037	0	0	0	17.00
18.00	Accumulated depreciation	-5,982,970	0	0	0	18.00
19.00	Fixed equipment	2,690,900	0	0	0	19.00
20.00	Accumulated depreciation	-1,690,697	0	0	0	20.00
21.00	Automobiles and trucks	154,026	0	0	0	21.00
22.00	Accumulated depreciation	-130,910	0	0	0	22.00
23.00	Major movable equipment	22,849,307	0	0	0	23.00
24.00	Accumulated depreciation	-14,577,313	0	0	0	24.00
25.00	Minor equipment depreciable	7,111,093	0	0	0	25.00
26.00	Accumulated depreciation	-4,515,115	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)	45,948,724	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	2,947,750	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,947,750	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	72,901,834	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,787,287	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,902,288	0	0	0	38.00
39.00	Payroll taxes payable	9	0	0	0	39.00
40.00	Notes and loans payable (short term)	33,333	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	-366,034,633	0	0	0	43.00
44.00	Other current liabilities	1,267,849	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-360,043,867	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	141,667	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,093,728	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,235,395	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-357,808,472	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	430,710,306				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)	430,710,306	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	72,901,834	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G-1 | Date/Time Prepared: 7/31/2018 2:39 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		392,430,626		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		38,279,680				2.00
3.00	Total (sum of line 1 and line 2)		430,710,306		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)		430,710,306		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)		430,710,306		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: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/31/2018 2:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,039,416		21,039,416	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)	21,039,416		21,039,416	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,858,102		2,858,102	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)	2,858,102		2,858,102	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,897,518		23,897,518	17.00
18.00	Ancillary services	123,427,592	321,016,840	444,444,432	18.00
19.00	Outpatient services	7,489,817	52,942,676	60,432,493	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	154,814,927	373,959,516	528,774,443	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,822,494		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)		73,822,494		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G-3 | Date/Time Prepared: 7/31/2018 2:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	528,774,443	1.00
2.00	Less contractual allowances and discounts on patients' accounts	417,014,203	2.00
3.00	Net patient revenues (line 1 minus line 2)	111,760,240	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	73,822,494	4.00
5.00	Net income from service to patients (line 3 minus line 4)	37,937,746	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 INCOME	341,934	24.00
25.00	Total other income (sum of lines 6-24)	341,934	25.00
26.00	Total (line 5 plus line 25)	38,279,680	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	38,279,680	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0133	Period: From 03/01/2017 To 02/28/2018	Worksheet L Parts I-III Date/Time Prepared: 7/31/2018 2:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	507,627	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	4,977	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	26.86	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	512,604	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00