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: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 1/16/2018 2:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/16/2018 Time: 2:58 pm
2. [ ] Manually submitted cost report
3. [1] 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. [5] 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 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 JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	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	12,845	17,506	-21,611	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	12,845	17,506	-21,611	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: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 1/16/2018 2:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	TODD AIKENS REHAB CENTER	15T001	26900	5	01/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	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.	175	359	0	0	670	56	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.	31	34	0	0	141		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 2:52 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	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 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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

		1.00	
	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 64-67. (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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 2:52 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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 Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	395,247	94,504	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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 2:52 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 2:52 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	12/31/2015	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)	Y	0	171.00

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/29/2016	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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/28/2016	Y	04/28/2016	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: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 1/16/2018 2:52 pm

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	NICHOLAS	EICHELMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.383.3781	NEICHELMAN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 1/16/2018 2:52 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.	SR. 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: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2018 2:52 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	80	29,200	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)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		86	31,390	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	11	5,107		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	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)		97				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 1/16/2018 2:52 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,448	132	4,702			1.00
2.00	HMO and other (see instructions)	896	1,029				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	96	175				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)	2,448	132	4,702			7.00
8.00	INTENSIVE CARE UNIT	256	26	935			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		18	650			13.00
14.00	Total (see instructions)	2,704	176	6,287	0.00	523.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	503	31	1,191	0.00	10.34	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	3,473	287	6,779	0.00	10.59	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	544.81	27.00
28.00	Observation Bed Days		0	893			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	56	124			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 1/16/2018 2:52 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	713	257	1,792	1.00
2.00	HMO and other (see instructions)			224	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	713	257	1,792	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	38	5	85	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	0.00					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						33.00

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	33,750,187	0	33,750,187	1,133,203.00	29.78	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)		10,628,722	-113,345	10,515,377	229,429.00	45.83	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,067,721	0	1,067,721	12,820.00	83.29	11.00
12.00	Contract labor: Top level management and other management and administrative services		196,087	0	196,087	6,158.00	31.84	12.00
13.00	Contract labor: Physician-Part A - Administrative		115,074	0	115,074	1,653.00	69.62	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,536,178	0	5,536,178			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,405,395	0	1,405,395			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							25.50
25.51	Related orgainzation wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,848,827	113,345	2,962,172	146,135.00	20.27	26.00
27.00	Administrative & General	5.00	1,860,549	0	1,860,549	62,413.00	29.81	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 1/16/2018 2:52 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	
28.00	Administrative & General under contract (see inst.)		217,575	0	217,575	795.00	273.68	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	608,085	0	608,085	29,384.00	20.69	30.00
31.00	Laundry & Linen Service	8.00	119,960	0	119,960	9,473.00	12.66	31.00
32.00	Housekeeping	9.00	640,436	0	640,436	53,447.00	11.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	748,737	-455,969	292,768	18,603.00	15.74	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	455,969	455,969	28,974.00	15.74	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,274,566	0	1,274,566	23,229.00	54.87	38.00
39.00	Central Services and Supply	14.00	73,222	0	73,222	4,263.00	17.18	39.00
40.00	Pharmacy	15.00	453,149	0	453,149	12,587.00	36.00	40.00
41.00	Medical Records & Medical Records Library	16.00	477,397	0	477,397	26,507.00	18.01	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: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part III Date/Time Prepared: 1/16/2018 2:52 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)		33,967,762	0	33,967,762	1,133,998.00	29.95	1.00
2.00	Excluded area salaries (see instructions)		10,628,722	-113,345	10,515,377	229,429.00	45.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,339,040	113,345	23,452,385	904,569.00	25.93	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,378,882	0	1,378,882	20,631.00	66.84	4.00
5.00	Subtotal wage-related costs (see inst.)		5,536,178	0	5,536,178	0.00	23.61	5.00
6.00	Total (sum of lines 3 thru 5)		30,254,100	113,345	30,367,445	925,200.00	32.82	6.00
7.00	Total overhead cost (see instructions)		9,322,503	113,345	9,435,848	415,810.00	22.69	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 1/16/2018 2:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	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	900,490	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	374,688	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,036,118	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,447	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	97,983	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	255,680	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,254,578	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	41,957	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	37,339	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,033,280	24.00
	Part B - Other than Core Related Cost		
25.00	EXCLUDED BENEFITS	1,499,495	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V | Date/Time Prepared: 1/16/2018 2:52 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4
Component CCN: 15-7510 | Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,767	0	0	1,767	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	158.00	15.00	186.00	359.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.15	0.00	1.15	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.25	0.00	2.25	5.00
6.00	Direct Nursing Service		4.24	0.00	4.24	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.67	0.00	1.67	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		1.19	0.00	1.19	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.05	0.00	0.05	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.02	0.00	0.02	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		18020			20.00
20.01			26900			20.01
20.02			50032			20.02

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,617	15	22	6	1,660	21.00
22.00	Skilled Nursing Visit Charges	371,910	3,450	5,060	1,380	381,800	22.00
23.00	Physical Therapy Visits	984	25	5	7	1,021	23.00
24.00	Physical Therapy Visit Charges	246,000	6,250	1,250	1,750	255,250	24.00
25.00	Occupational Therapy Visits	714	14	5	7	740	25.00
26.00	Occupational Therapy Visit Charges	178,500	3,500	1,250	1,750	185,000	26.00
27.00	Speech Pathology Visits	18	0	0	0	18	27.00
28.00	Speech Pathology Visit Charges	4,500	0	0	0	4,500	28.00
29.00	Medical Social Service Visits	4	0	0	0	4	29.00
30.00	Medical Social Service Visit Charges	1,080	0	0	0	1,080	30.00
31.00	Home Health Aide Visits	30	0	0	0	30	31.00
32.00	Home Health Aide Visit Charges	3,000	0	0	0	3,000	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,367	54	32	20	3,473	33.00
34.00	Other Charges	13,823	0	42	0	13,865	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	818,813	13,200	7,602	4,880	844,495	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 1/16/2018 2:52 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)	0.291285	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,153,124	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 or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	1,969,786	5.00
6.00	Medicaid charges	29,172,705	6.00
7.00	Medicaid cost (line 1 times line 6)	8,497,571	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,169,216	0	4,169,216	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,214,430	0	1,214,430	21.00
22.00	Payments received from patients for amounts previously written off as charity care	98,215	0	98,215	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,116,215	0	1,116,215	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	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)	5,331,463	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	233,802	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	359,695	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	4,971,768	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,574,094	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,690,309	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,690,309	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A
Date/Time Prepared: 1/16/2018 2:52 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		1,746,722	1,746,722	0	1,746,722	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER		86,509	86,509	0	86,509	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,703,810	2,703,810	0	2,703,810	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	242,108	7,082,964	7,325,072	129,503	7,454,575	4.00
4.01	00401	COMMUNICATIONS	197,347	276,668	474,015	0	474,015	4.01
4.02	00402	DATA PROCESSING	759,339	665,472	1,424,811	0	1,424,811	4.02
4.03	00403	MATERIALS MANAGEMENT	229,947	46,951	276,898	0	276,898	4.03
4.04	00404	ADMITTING	570,159	30,095	600,254	0	600,254	4.04
4.05	00405	PATIENT ACCOUNTING	849,927	634,275	1,484,202	0	1,484,202	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,860,549	4,392,283	6,252,832	0	6,252,832	5.00
7.00	00700	OPERATION OF PLANT	608,085	1,978,812	2,586,897	0	2,586,897	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	119,960	70,856	190,816	0	190,816	8.00
9.00	00900	HOUSEKEEPING	640,436	113,296	753,732	0	753,732	9.00
10.00	01000	DIETARY	748,737	310,910	1,059,647	-645,303	414,344	10.00
11.00	01100	CAFETERIA	0	0	0	645,303	645,303	11.00
13.00	01300	NURSING ADMINISTRATION	1,274,566	223,734	1,498,300	0	1,498,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,222	108,800	182,022	0	182,022	14.00
15.00	01500	PHARMACY	453,149	3,425,564	3,878,713	0	3,878,713	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	477,397	245,233	722,630	0	722,630	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,970,575	748,775	3,719,350	-202,175	3,517,175	30.00
31.00	03100	INTENSIVE CARE UNIT	1,081,414	111,047	1,192,461	0	1,192,461	31.00
41.00	04100	SUBPROVIDER - IRF	586,250	138,335	724,585	0	724,585	41.00
43.00	04300	NURSERY	0	0	0	202,175	202,175	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,735,743	728,784	2,464,527	0	2,464,527	50.00
53.00	05300	ANESTHESIOLOGY	0	20,563	20,563	0	20,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,961,053	936,022	2,897,075	0	2,897,075	54.00
60.00	06000	LABORATORY	1,397,547	1,751,458	3,149,005	0	3,149,005	60.00
65.00	06500	RESPIRATORY THERAPY	853,705	145,627	999,332	0	999,332	65.00
66.00	06600	PHYSICAL THERAPY	690,130	45,382	735,512	0	735,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,129	26	210,155	0	210,155	67.00
68.00	06800	SPEECH PATHOLOGY	121,646	6,206	127,852	0	127,852	68.00
69.00	06900	ELECTROCARDIOLOGY	391,596	307,177	698,773	0	698,773	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,216	7,229	54,445	0	54,445	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,074,054	3,074,054	-1,451,289	1,622,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,451,289	1,451,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	149,713	30,145	179,858	0	179,858	76.00
76.97	07697	CARDIAC REHABILITATION	109,040	21,545	130,585	0	130,585	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	575,649	2,115,706	2,691,355	0	2,691,355	90.00
91.00	09100	EMERGENCY	1,721,381	395,171	2,116,552	0	2,116,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	681,436	179,608	861,044	0	861,044	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,177	2,177	0	2,177	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,389,151	34,907,991	59,297,142	129,503	59,426,645	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,686	28,758	88,444	0	88,444	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,576,910	3,237,096	11,814,006	0	11,814,006	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	80,467	6,721	87,188	0	87,188	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	530,825	76,419	607,244	-129,503	477,741	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	901,902	901,902	0	901,902	193.03
194.00	07950	PARTNERSHIP HFC	23,520	5,594	29,114	0	29,114	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	48,000	48,000	0	48,000	194.03
194.04	07954	ATHLETIC TRAINERS	89,628	12,978	102,606	0	102,606	194.04
200.00		TOTAL (SUM OF LINES 118-199)	33,750,187	39,225,459	72,975,646	0	72,975,646	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 1/16/2018 2:52 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	83,182	1,829,904	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,703,810	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-138,942	7,315,633	4.00
4.01	00401	COMMUNICATIONS	-17,193	456,822	4.01
4.02	00402	DATA PROCESSING	0	1,424,811	4.02
4.03	00403	MATERIALS MANAGEMENT	0	276,898	4.03
4.04	00404	ADMITTING	0	600,254	4.04
4.05	00405	PATIENT ACCOUNTING	-9,059	1,475,143	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-2,611,843	3,640,989	5.00
7.00	00700	OPERATION OF PLANT	-42,583	2,544,314	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,816	8.00
9.00	00900	HOUSEKEEPING	0	753,732	9.00
10.00	01000	DIETARY	-2,849	411,495	10.00
11.00	01100	CAFETERIA	-271,153	374,150	11.00
13.00	01300	NURSING ADMINISTRATION	-30,218	1,468,082	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	182,022	14.00
15.00	01500	PHARMACY	-6,428	3,872,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28,843	693,787	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-784,290	2,732,885	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,192,461	31.00
41.00	04100	SUBPROVIDER - IRF	0	724,585	41.00
43.00	04300	NURSERY	0	202,175	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-34,027	2,430,500	50.00
53.00	05300	ANESTHESIOLOGY	0	20,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,178	2,893,897	54.00
60.00	06000	LABORATORY	0	3,149,005	60.00
65.00	06500	RESPIRATORY THERAPY	-7,000	992,332	65.00
66.00	06600	PHYSICAL THERAPY	0	735,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	210,155	67.00
68.00	06800	SPEECH PATHOLOGY	0	127,852	68.00
69.00	06900	ELECTROCARDIOLOGY	-51,580	647,193	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	54,445	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,622,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,451,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	ONCOLOGY	0	179,858	76.00
76.97	07697	CARDIAC REHABILITATION	0	130,585	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	-172,037	2,519,318	90.00
91.00	09100	EMERGENCY	-133,448	1,983,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	861,044	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	-2,177	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,263,666	55,162,979	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	88,444	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,814,006	192.00
192.01	19201	SOUTH CLINIC	0	0	192.01
192.02	19202	WEST CLINIC	0	0	192.02
192.03	19203	DIABETES CENTER	0	87,188	192.03
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	477,741	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	901,902	193.03
194.00	07950	PARTNERSHIP HFC	0	29,114	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	194.01
194.02	07952	EDINBURGH	0	0	194.02
194.03	07953	JAIL	0	48,000	194.03
194.04	07954	ATHLETIC TRAINERS	0	102,606	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-4,263,666	68,711,980	200.00

RECLASSIFICATIONS

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 1/16/2018 2:52 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	455,969	189,334	1.00
	TOTALS		455,969	189,334	
	B - CHILD CARE RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	113,345	16,158	1.00
	TOTALS		113,345	16,158	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	176,154	26,021	1.00
	TOTALS		176,154	26,021	
	D - IMPLANTABLE DEVICE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,451,289	1.00
	TOTALS		0	1,451,289	
500.00	Grand Total: Increases		745,468	1,682,802	500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 1/16/2018 2:52 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	455,969	189,334	0	1.00
	TOTALS		455,969	189,334		
	B - CHILD CARE RECLASS					
1.00	ADULT/CHILD CARE	193.01	113,345	16,158	0	1.00
	TOTALS		113,345	16,158		
	C - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	176,154	26,021	0	1.00
	TOTALS		176,154	26,021		
	D - IMPLANTABLE DEVICE RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,451,289	0	1.00
	TOTALS		0	1,451,289		
500.00	Grand Total: Decreases		745,468	1,682,802		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 1/16/2018 2:52 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	3,141,963	1,764,926	0	1,764,926	163,560	1.00
2.00	Land Improvements	1,603,865	19,836	0	19,836	160,516	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	68,738,750	9,114,129	-2,622,224	6,491,905	8,286,524	4.00
5.00	Fixed Equipment	11,690,283	422,876	710,934	1,133,810	0	5.00
6.00	Movable Equipment	36,227,029	0	1,911,290	1,911,290	298,289	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,401,890	11,321,767	0	11,321,767	8,908,889	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	121,401,890	11,321,767	0	11,321,767	8,908,889	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,743,329	0	1.00
2.00	Land Improvements	1,463,185	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	66,944,131	0	4.00
5.00	Fixed Equipment	12,824,093	0	5.00
6.00	Movable Equipment	37,840,030	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	123,814,768	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	123,814,768	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II Date/Time Prepared: 1/16/2018 2:52 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	1,746,722	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,703,810	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,537,041	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	1,746,722	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,703,810	2.00
3.00	Total (sum of lines 1-2)	0	4,537,041	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 1/16/2018 2:52 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	85,974,738	0	85,974,738	0.694382	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	37,840,030	0	37,840,030	0.305618	0	2.00
3.00	Total (sum of lines 1-2)	123,814,768	0	123,814,768	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,829,904	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	86,509	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,703,810	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,620,223	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,829,904	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,703,810	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,620,223	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 1/16/2018 2:52 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
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1.01
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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,019,095			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - TOWER		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 1/16/2018 2:52 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	JMH PAIN CARE CENTER REV OPERATING F	B	-172,037	CLINIC	90.00	0	33.00
34.00	JMH NUTR SVCS DISCOUNTS OPERATING FU	B	80	DIETARY	10.00	0	34.00
35.00	JMH PURCHASES DISCOUNTS OPERATING FU	B	-4,385	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	JMH SALE OF FILM	B	-178	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	JMH CAFETERIA REV OPERATING FUND	B	-271,153	CAFETERIA	11.00	0	37.00
38.00	JMH CATERING REV OPERATING FUND	B	-2,929	DIETARY	10.00	0	38.00
39.00	JMH MISC PHARM REVENUE OPERATING FUN	B	-6,428	PHARMACY	15.00	0	39.00
40.00	JMH RENT OF SPACE	B	-5,110	OPERATION OF PLANT	7.00	0	40.00
41.00	JMH MEDICAL RECORD FEES OPERATING FU	B	-28,843	MEDICAL RECORDS & LIBRARY	16.00	0	41.00
42.00	JMH GEN ACCOUNTING REV OPERATING FUN	B	-7,680	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	JMH RETURNED CHECK FEES OPERATING FU	B	-350	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	JMH EDUCATION PROGRAMS OPERATING FUN	B	-175	NURSING ADMINISTRATION	13.00	0	44.00
44.01	JMH BILLING SERVICES REV OPERATING F	B	-9,059	PATIENT ACCOUNTING	4.05	0	44.01
44.02	JMH MISC REV GRANT	B	-1,912	ADMINISTRATIVE & GENERAL	5.00	0	44.02
45.00	1993 AHA LIFE ADJUSTMENT	A	84,563	CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01	MED STAFF OTHER EXP	A	-140	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	CABLE SERVICES	A	-26,481	OPERATION OF PLANT	7.00	0	45.02
45.03	TELEPHONE SERVICES	A	-1,381	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04	TELEPHONE SERVICES	A	-19,111	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	COMMUNICATIONS	A	-17,193	COMMUNICATIONS	4.01	0	45.05
45.06	ADVERTISING EXP-A&G	A	-248,472	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.08	ADVERTISING EXP -NURSING ADMIN	A	-30,043	NURSING ADMINISTRATION	13.00	0	45.08
45.13	DAYCARE	B	-135,866	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.13
45.14	LOBBYING EXPENSE-AHA	A	-4,892	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	LOBBYING EXPENSE-IHHA	A	-1,353	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	PROF - BUILDING	A	-10,992	OPERATION OF PLANT	7.00	0	45.16
45.17	PROF - BUILDING	A	-3,076	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.17
45.19	INTEREST INCOME	B	-2,177	INTEREST EXPENSE	113.00	0	45.19
46.00	HOSPITAL ASSESSMENT FEE	A	-2,317,798	ADMINISTRATIVE & GENERAL	5.00	0	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,263,666				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2018 2:52 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	5.00	ADMINISTRATIVE & GENERAL	5,750	5,750	0	225,300	0	1.00
2.00	41.00	SUBPROVIDER - IRF	105,050	0	105,050	225,300	995	2.00
3.00	50.00	OPERATING ROOM	34,027	34,027	0	225,300	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	3,000	3,000	0	225,300	0	4.00
5.00	60.00	LABORATORY	110,004	0	110,004	225,300	1,575	5.00
6.00	65.00	RESPIRATORY THERAPY	7,000	7,000	0	225,300	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	51,580	51,580	0	225,300	0	7.00
8.00	91.00	EMERGENCY	138,518	133,448	5,070	225,300	78	8.00
9.00	30.00	ADULTS & PEDIATRICS	784,290	784,290	0	225,300	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,239,219	1,019,095	220,124		2,648	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	107,776	5,389	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	170,600	8,530	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	8,449	422	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			286,825	14,341	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	5,750	1.00
2.00	41.00	SUBPROVIDER - IRF	0	107,776	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	34,027	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,000	4.00
5.00	60.00	LABORATORY	0	170,600	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	7,000	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	51,580	7.00
8.00	91.00	EMERGENCY	0	8,449	0	133,448	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	784,290	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	286,825	0	1,019,095	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,829,904	1,829,904				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	86,509			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,703,810			2,703,810		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,315,633	19,528	0	1,910	7,337,071	4.00
4.01	00401	COMMUNICATIONS	456,822	2,572	0	0	43,359	4.01
4.02	00402	DATA PROCESSING	1,424,811	40,968	0	1,372,928	166,832	4.02
4.03	00403	MATERIALS MANAGEMENT	276,898	25,039	0	5,852	50,521	4.03
4.04	00404	ADMITTING	600,254	14,653	1,842	0	125,268	4.04
4.05	00405	PATIENT ACCOUNTING	1,475,143	43,520	0	10,139	186,735	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	3,640,989	62,341	0	26,108	408,776	5.00
7.00	00700	OPERATION OF PLANT	2,544,314	163,347	12,498	30,103	133,601	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190,816	15,733	0	4,298	26,356	8.00
9.00	00900	HOUSEKEEPING	753,732	12,218	937	2,413	140,708	9.00
10.00	01000	DIETARY	411,495	25,634	554	14,568	64,323	10.00
11.00	01100	CAFETERIA	374,150	27,296	0	0	100,180	11.00
13.00	01300	NURSING ADMINISTRATION	1,468,082	64,573	0	31,974	280,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	182,022	11,119	0	30,057	16,087	14.00
15.00	01500	PHARMACY	3,872,285	13,390	0	4,798	99,560	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	693,787	25,386	0	4,669	104,887	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,732,885	180,473	19,566	136,105	613,954	30.00
31.00	03100	INTENSIVE CARE UNIT	1,192,461	51,609	8,861	24,315	237,594	31.00
41.00	04100	SUBPROVIDER - IRF	724,585	44,259	7,599	14,173	128,803	41.00
43.00	04300	NURSERY	202,175	4,090	0	0	38,702	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,430,500	299,476	802	355,895	381,355	50.00
53.00	05300	ANESTHESIOLOGY	20,563	2,578	0	13,415	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,893,897	108,191	12,062	287,598	430,857	54.00
60.00	06000	LABORATORY	3,149,005	52,675	6,924	126,017	307,051	60.00
65.00	06500	RESPIRATORY THERAPY	992,332	22,081	1,203	20,883	187,565	65.00
66.00	06600	PHYSICAL THERAPY	735,512	41,478	0	9,280	151,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,155	8,737	0	1,953	46,167	67.00
68.00	06800	SPEECH PATHOLOGY	127,852	543	93	324	26,726	68.00
69.00	06900	ELECTROCARDIOLOGY	647,193	7,068	99	32,410	86,036	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	54,445	1,191	204	1,432	10,374	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,622,765	0	0	10,522	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,451,289	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	179,858	45,804	0	2,699	32,893	76.00
76.97	07697	CARDIAC REHABILITATION	130,585	16,433	0	2,087	23,957	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,519,318	75,365	496	13,541	126,474	90.00
91.00	09100	EMERGENCY	1,983,104	65,012	10,860	34,997	378,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	861,044	8,540	0	733	149,716	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,162,979	1,602,920	84,600	2,628,196	5,305,273	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,444	8,488	1,457	2,155	13,113	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,814,006	169,662	0	73,172	1,884,423	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	87,188	2,631	452	287	17,679	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	477,741	31,622	0	0	91,723	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	901,902	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	29,114	14,581	0	0	5,168	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	102,606	0	0	0	19,692	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	68,711,980	1,829,904	86,509	2,703,810	7,337,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	502,753					4.01
4.02	00402	DATA PROCESSING	59,533	3,065,072				4.02
4.03	00403	MATERIALS MANAGEMENT	10,754	49,839	418,903			4.03
4.04	00404	ADMITTING	9,218	0	1,780	753,015		4.04
4.05	00405	PATIENT ACCOUNTING	31,878	471,685	2,563	0	2,221,663	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	28,806	250,973	5,534	0	0	5.00
7.00	00700	OPERATION OF PLANT	14,979	39,159	108	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,920	7,120	37	0	0	8.00
9.00	00900	HOUSEKEEPING	5,377	0	83	0	0	9.00
10.00	01000	DIETARY	9,602	129,936	12,554	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,131	0	4,280	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,356	0	0	14.00
15.00	01500	PHARMACY	6,529	42,719	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,747	192,234	165	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,023	441,427	10,899	45,251	133,499	30.00
31.00	03100	INTENSIVE CARE UNIT	10,754	0	3,253	6,692	19,742	31.00
41.00	04100	SUBPROVIDER - IRF	6,913	110,357	977	6,422	18,945	41.00
43.00	04300	NURSERY	0	0	0	2,459	7,256	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,110	283,012	21,670	123,204	363,476	50.00
53.00	05300	ANESTHESIOLOGY	0	0	90	11,010	32,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,972	288,352	16,554	153,801	453,865	54.00
60.00	06000	LABORATORY	26,117	0	59,925	110,867	327,080	60.00
65.00	06500	RESPIRATORY THERAPY	6,913	119,257	6,181	21,538	63,541	65.00
66.00	06600	PHYSICAL THERAPY	8,066	42,719	1,334	13,665	40,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,536	8,900	2	7,458	22,004	67.00
68.00	06800	SPEECH PATHOLOGY	1,536	5,340	6	2,632	7,766	68.00
69.00	06900	ELECTROCARDIOLOGY	15,363	0	2,382	20,762	61,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	768	0	72	656	1,934	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	183,067	23,548	69,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,010	56,082	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,270	139,456	73.00
76.00	03020	ONCOLOGY	14,211	26,699	698	2,759	8,140	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	546	2,004	5,912	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,913	131,716	31,533	48,560	143,262	90.00
91.00	09100	EMERGENCY	21,508	0	5,639	76,230	224,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,066	0	863	7,217	21,290	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	428,243	2,641,444	376,151	753,015	2,221,663	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,761	71,198	786	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	58,763	352,430	37,393	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1,152	0	18	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	5,761	0	4,387	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	3,073	0	159	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	9	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	502,753	3,065,072	418,903	753,015	2,221,663	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	4,423,527	4,423,527				5.00
7.00	00700	OPERATION OF PLANT	2,938,109	202,162	3,140,271			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	246,280	16,946	33,887	297,113		8.00
9.00	00900	HOUSEKEEPING	915,468	62,991	26,317	55,434	1,060,210	9.00
10.00	01000	DIETARY	668,666	46,009	55,214	3,963	19,006	10.00
11.00	01100	CAFETERIA	501,626	34,515	58,794	0	20,238	11.00
13.00	01300	NURSING ADMINISTRATION	1,865,071	128,330	139,085	0	47,875	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	242,641	16,695	23,949	0	8,244	14.00
15.00	01500	PHARMACY	4,039,281	277,931	28,840	0	9,927	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,036,875	71,344	54,678	0	18,821	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,352,082	299,454	388,724	71,716	133,805	30.00
31.00	03100	INTENSIVE CARE UNIT	1,555,281	107,014	111,161	20,893	38,263	31.00
41.00	04100	SUBPROVIDER - IRF	1,063,033	73,144	95,331	10,798	32,815	41.00
43.00	04300	NURSERY	254,682	17,524	8,810	0	3,033	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,290,500	295,216	645,047	62,341	222,035	50.00
53.00	05300	ANESTHESIOLOGY	80,138	5,514	5,554	0	1,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,665,149	320,995	233,034	18,031	80,214	54.00
60.00	06000	LABORATORY	4,165,661	286,627	113,458	0	39,054	60.00
65.00	06500	RESPIRATORY THERAPY	1,441,494	99,185	47,560	0	16,371	65.00
66.00	06600	PHYSICAL THERAPY	1,043,996	71,834	89,340	1,351	30,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	306,912	21,118	18,818	0	6,478	67.00
68.00	06800	SPEECH PATHOLOGY	172,818	11,891	1,170	0	403	68.00
69.00	06900	ELECTROCARDIOLOGY	872,566	60,039	15,224	1,478	5,240	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,076	4,891	2,565	0	883	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,909,372	131,378	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,526,381	105,026	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	186,726	12,848	0	0	0	73.00
76.00	03020	ONCOLOGY	313,761	21,589	98,658	0	33,960	76.00
76.97	07697	CARDIAC REHABILITATION	181,524	12,490	35,395	0	12,184	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,097,178	213,108	162,329	2,096	55,876	90.00
91.00	09100	EMERGENCY	2,800,441	192,690	140,029	42,635	48,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,057,469	72,761	18,395	0	6,332	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,285,784	3,293,259	2,651,366	290,736	891,921	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	191,402	13,170	18,282	0	6,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,389,849	990,152	365,438	6,377	125,790	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	109,407	7,528	5,667	0	1,951	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	611,234	42,057	68,112	0	23,445	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	901,902	62,057	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	52,095	3,585	31,406	0	10,810	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	3,303	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	122,307	8,416	0	0	0	194.04
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 118-201)	68,711,980	4,423,527	3,140,271	297,113	1,060,210	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 1/16/2018 2:52 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
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	792,858					10.00
11.00	01100	CAFETERIA	0	615,173				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,209	2,198,570			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,342	0	294,871		14.00
15.00	01500	PHARMACY	0	9,867	0	0	4,365,846	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,778	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	548,389	69,075	717,633	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	107,516	28,777	298,971	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	136,953	16,860	175,159	0	0	41.00
43.00	04300	NURSERY	0	4,952	51,445	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	47,096	489,286	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,174	0	0	0	54.00
60.00	06000	LABORATORY	0	49,753	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,878	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,954	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,816	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,689	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,875	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,423	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	294,871	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	4,365,846	73.00
76.00	03020	ONCOLOGY	0	4,640	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,959	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,207	0	0	0	90.00
91.00	09100	EMERGENCY	0	44,862	466,076	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	17,260	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	792,858	469,446	2,198,570	294,871	4,365,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,843	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	106,930	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	1,997	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	26,140	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	3,785	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	4,032	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	792,858	615,173	2,198,570	294,871	4,365,846	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 1/16/2018 2:52 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
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,202,496					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,254	6,653,132	0	6,653,132		30.00
31.00	03100	INTENSIVE CARE UNIT	10,685	2,278,561	0	2,278,561		31.00
41.00	04100	SUBPROVIDER - IRF	10,254	1,614,347	0	1,614,347		41.00
43.00	04300	NURSERY	3,927	344,373	0	344,373		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	196,725	6,248,246	0	6,248,246		50.00
53.00	05300	ANESTHESIOLOGY	17,580	110,698	0	110,698		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,707	5,614,304	0	5,614,304		54.00
60.00	06000	LABORATORY	177,026	4,831,579	0	4,831,579		60.00
65.00	06500	RESPIRATORY THERAPY	34,390	1,661,878	0	1,661,878		65.00
66.00	06600	PHYSICAL THERAPY	21,820	1,277,047	0	1,277,047		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,909	370,051	0	370,051		67.00
68.00	06800	SPEECH PATHOLOGY	4,203	193,174	0	193,174		68.00
69.00	06900	ELECTROCARDIOLOGY	33,152	996,574	0	996,574		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,047	81,885	0	81,885		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,600	2,373,221	0	2,373,221		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,353	1,661,760	0	1,661,760		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,478	4,640,898	0	4,640,898		73.00
76.00	03020	ONCOLOGY	4,406	477,014	0	477,014		76.00
76.97	07697	CARDIAC REHABILITATION	3,200	247,752	0	247,752		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,538	3,629,332	0	3,629,332		90.00
91.00	09100	EMERGENCY	121,719	3,856,652	0	3,856,652		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	11,523	1,183,740	0	1,183,740		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,202,496	50,346,218	0	50,346,218		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	231,990	0	231,990		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,984,536	0	15,984,536		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	126,550	0	126,550		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	770,988	0	770,988		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	963,959	0	963,959		193.03
194.00	07950	PARTNERSHIP HFC	0	101,681	0	101,681		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	51,303	0	51,303		194.03
194.04	07954	ATHLETIC TRAINERS	0	134,755	0	134,755		194.04
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 118-201)	1,202,496	68,711,980	0	68,711,980		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,528	0	1,910	21,438	4.00
4.01	00401	COMMUNICATIONS	0	2,572	0	0	2,572	4.01
4.02	00402	DATA PROCESSING	0	40,968	0	1,372,928	1,413,896	4.02
4.03	00403	MATERIALS MANAGEMENT	0	25,039	0	5,852	30,891	4.03
4.04	00404	ADMITTING	0	14,653	1,842	0	16,495	4.04
4.05	00405	PATIENT ACCOUNTING	0	43,520	0	10,139	53,659	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	62,341	0	26,108	88,449	5.00
7.00	00700	OPERATION OF PLANT	0	163,347	12,498	30,103	205,948	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,733	0	4,298	20,031	8.00
9.00	00900	HOUSEKEEPING	0	12,218	937	2,413	15,568	9.00
10.00	01000	DIETARY	0	25,634	554	14,568	40,756	10.00
11.00	01100	CAFETERIA	0	27,296	0	0	27,296	11.00
13.00	01300	NURSING ADMINISTRATION	0	64,573	0	31,974	96,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,119	0	30,057	41,176	14.00
15.00	01500	PHARMACY	0	13,390	0	4,798	18,188	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,386	0	4,669	30,055	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	180,473	19,566	136,105	336,144	30.00
31.00	03100	INTENSIVE CARE UNIT	0	51,609	8,861	24,315	84,785	31.00
41.00	04100	SUBPROVIDER - IRF	0	44,259	7,599	14,173	66,031	41.00
43.00	04300	NURSERY	0	4,090	0	0	4,090	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	299,476	802	355,895	656,173	50.00
53.00	05300	ANESTHESIOLOGY	0	2,578	0	13,415	15,993	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	108,191	12,062	287,598	407,851	54.00
60.00	06000	LABORATORY	0	52,675	6,924	126,017	185,616	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,081	1,203	20,883	44,167	65.00
66.00	06600	PHYSICAL THERAPY	0	41,478	0	9,280	50,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,737	0	1,953	10,690	67.00
68.00	06800	SPEECH PATHOLOGY	0	543	93	324	960	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,068	99	32,410	39,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,191	204	1,432	2,827	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,522	10,522	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	03020	ONCOLOGY	0	45,804	0	2,699	48,503	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,433	0	2,087	18,520	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	75,365	496	13,541	89,402	90.00
91.00	09100	EMERGENCY	0	65,012	10,860	34,997	110,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,540	0	733	9,273	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,602,920	84,600	2,628,196	4,315,716	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,488	1,457	2,155	12,100	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	169,662	0	73,172	242,834	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	2,631	452	287	3,370	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	31,622	0	0	31,622	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	14,581	0	0	14,581	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,829,904	86,509	2,703,810	4,620,223	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	
			4.00	4.01	4.02	4.03	4.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,438					4.00
4.01	00401	COMMUNICATIONS	127	2,699				4.01
4.02	00402	DATA PROCESSING	487	323	1,414,706			4.02
4.03	00403	MATERIALS MANAGEMENT	148	58	23,003	54,100		4.03
4.04	00404	ADMITTING	366	49	0	230	17,140	4.04
4.05	00405	PATIENT ACCOUNTING	546	171	217,710	331	0	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,194	155	115,838	715	0	5.00
7.00	00700	OPERATION OF PLANT	390	80	18,074	14	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77	10	3,286	5	0	8.00
9.00	00900	HOUSEKEEPING	411	29	0	11	0	9.00
10.00	01000	DIETARY	188	52	59,973	1,621	0	10.00
11.00	01100	CAFETERIA	293	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	818	87	0	553	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47	0	0	433	0	14.00
15.00	01500	PHARMACY	291	35	19,717	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	306	85	88,727	21	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,794	204	203,744	1,407	1,028	30.00
31.00	03100	INTENSIVE CARE UNIT	694	58	0	420	152	31.00
41.00	04100	SUBPROVIDER - IRF	376	37	50,936	126	146	41.00
43.00	04300	NURSERY	113	0	0	0	56	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,114	167	130,626	2,798	2,799	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12	250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,259	107	133,091	2,138	3,525	54.00
60.00	06000	LABORATORY	897	140	0	7,739	2,519	60.00
65.00	06500	RESPIRATORY THERAPY	548	37	55,044	798	489	65.00
66.00	06600	PHYSICAL THERAPY	443	43	19,717	172	311	66.00
67.00	06700	OCCUPATIONAL THERAPY	135	8	4,108	0	169	67.00
68.00	06800	SPEECH PATHOLOGY	78	8	2,465	1	60	68.00
69.00	06900	ELECTROCARDIOLOGY	251	82	0	308	472	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30	4	0	9	15	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,646	535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,074	73.00
76.00	03020	ONCOLOGY	96	76	12,323	90	63	76.00
76.97	07697	CARDIAC REHABILITATION	70	0	0	70	46	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	370	37	60,795	4,072	1,103	90.00
91.00	09100	EMERGENCY	1,105	115	0	728	1,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	437	43	0	111	164	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,499	2,300	1,219,177	48,579	17,140	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38	31	32,862	102	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,508	315	162,667	4,829	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	52	6	0	2	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	268	31	0	567	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	15	16	0	20	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	58	0	0	1	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,438	2,699	1,414,706	54,100	17,140	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING	272,417					4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	206,351				5.00
7.00	00700	OPERATION OF PLANT	0	9,431	233,937			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	791	2,524	26,724		8.00
9.00	00900	HOUSEKEEPING	0	2,939	1,961	4,986	25,905	9.00
10.00	01000	DIETARY	0	2,146	4,113	356	464	10.00
11.00	01100	CAFETERIA	0	1,610	4,380	0	494	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,987	10,361	0	1,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	779	1,784	0	201	14.00
15.00	01500	PHARMACY	0	12,966	2,148	0	243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,328	4,073	0	460	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,368	13,970	28,958	6,450	3,269	30.00
31.00	03100	INTENSIVE CARE UNIT	2,421	4,992	8,281	1,879	935	31.00
41.00	04100	SUBPROVIDER - IRF	2,323	3,412	7,102	971	802	41.00
43.00	04300	NURSERY	890	818	656	0	74	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,565	13,773	48,054	5,607	5,424	50.00
53.00	05300	ANESTHESIOLOGY	3,983	257	414	0	47	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,670	14,975	17,360	1,622	1,960	54.00
60.00	06000	LABORATORY	40,102	13,372	8,452	0	954	60.00
65.00	06500	RESPIRATORY THERAPY	7,791	4,627	3,543	0	400	65.00
66.00	06600	PHYSICAL THERAPY	4,943	3,351	6,655	122	751	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,698	985	1,402	0	158	67.00
68.00	06800	SPEECH PATHOLOGY	952	555	87	0	10	68.00
69.00	06900	ELECTROCARDIOLOGY	7,510	2,801	1,134	133	128	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	237	228	191	0	22	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,518	6,129	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,876	4,900	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,098	599	0	0	0	73.00
76.00	03020	ONCOLOGY	998	1,007	7,350	0	830	76.00
76.97	07697	CARDIAC REHABILITATION	725	583	2,637	0	298	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,565	9,942	12,093	189	1,365	90.00
91.00	09100	EMERGENCY	27,574	8,989	10,432	3,835	1,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,610	3,394	1,370	0	155	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	272,417	153,636	197,515	26,150	21,792	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	614	1,362	0	154	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	46,179	27,224	574	3,074	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	351	422	0	48	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	1,962	5,074	0	573	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,895	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	167	2,340	0	264	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	154	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	393	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	272,417	206,351	233,937	26,724	25,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/16/2018 2:52 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
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	109,669					10.00
11.00	01100	CAFETERIA	0	34,073				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,009	116,532			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	185	0	44,605		14.00
15.00	01500	PHARMACY	0	547	0	0	54,135	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,151	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,853	3,826	38,036	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,872	1,594	15,847	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	18,944	934	9,284	0	0	41.00
43.00	04300	NURSERY	0	274	2,727	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,609	25,934	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,834	0	0	0	54.00
60.00	06000	LABORATORY	0	2,756	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,267	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	994	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	267	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	149	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	492	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	79	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	44,605	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	54,135	73.00
76.00	03020	ONCOLOGY	0	257	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	164	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,175	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,485	24,704	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	956	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	109,669	26,004	116,532	44,605	54,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	157	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,920	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	111	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	1,448	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	210	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	223	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	109,669	34,073	116,532	44,605	54,135	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/16/2018 2:52 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
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,206					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,706	738,757	0	738,757		30.00
31.00	03100	INTENSIVE CARE UNIT	1,140	138,070	0	138,070		31.00
41.00	04100	SUBPROVIDER - IRF	1,094	162,518	0	162,518		41.00
43.00	04300	NURSERY	419	10,117	0	10,117		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,982	960,625	0	960,625		50.00
53.00	05300	ANESTHESIOLOGY	1,875	22,831	0	22,831		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,159	668,551	0	668,551		54.00
60.00	06000	LABORATORY	18,881	281,428	0	281,428		60.00
65.00	06500	RESPIRATORY THERAPY	3,668	122,379	0	122,379		65.00
66.00	06600	PHYSICAL THERAPY	2,327	90,587	0	90,587		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,270	21,890	0	21,890		67.00
68.00	06800	SPEECH PATHOLOGY	448	5,773	0	5,773		68.00
69.00	06900	ELECTROCARDIOLOGY	3,536	56,424	0	56,424		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	112	3,754	0	3,754		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,010	97,965	0	97,965		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,237	15,445	0	15,445		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,050	80,956	0	80,956		73.00
76.00	03020	ONCOLOGY	470	72,063	0	72,063		76.00
76.97	07697	CARDIAC REHABILITATION	341	23,454	0	23,454		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,270	206,378	0	206,378		90.00
91.00	09100	EMERGENCY	12,982	206,728	0	206,728		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,229	19,742	0	19,742		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,206	4,006,435	0	4,006,435		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,420	0	47,420		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	499,124	0	499,124		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	4,362	0	4,362		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	41,545	0	41,545		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,895	0	2,895		193.03
194.00	07950	PARTNERSHIP HFC	0	17,613	0	17,613		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	154	0	154		194.03
194.04	07954	ATHLETIC TRAINERS	0	675	0	675		194.04
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 118-201)	128,206	4,620,223	0	4,620,223		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT P HONES)	
			1.00	1.01	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	279,616					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	76,991				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,692,463			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	0	1,902	33,394,734		4.00
4.01	00401	COMMUNICATIONS	393	0	0	197,347	1,309	4.01
4.02	00402	DATA PROCESSING	6,260	0	1,367,165	759,339	155	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	0	5,827	229,947	28	4.03
4.04	00404	ADMITTING	2,239	1,639	0	570,159	24	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	0	10,096	849,927	83	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	0	25,998	1,860,549	75	5.00
7.00	00700	OPERATION OF PLANT	24,960	11,123	29,977	608,085	39	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	0	4,280	119,960	5	8.00
9.00	00900	HOUSEKEEPING	1,867	834	2,403	640,436	14	9.00
10.00	01000	DIETARY	3,917	493	14,507	292,768	25	10.00
11.00	01100	CAFETERIA	4,171	0	0	455,969	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	31,840	1,274,566	42	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	29,931	73,222	0	14.00
15.00	01500	PHARMACY	2,046	0	4,778	453,149	17	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	4,649	477,397	41	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	17,413	135,534	2,794,421	99	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	7,886	24,213	1,081,414	28	31.00
41.00	04100	SUBPROVIDER - IRF	6,763	6,763	14,114	586,250	18	41.00
43.00	04300	NURSERY	625	0	0	176,154	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	714	354,402	1,735,743	81	50.00
53.00	05300	ANESTHESIOLOGY	394	0	13,359	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	10,735	286,391	1,961,053	52	54.00
60.00	06000	LABORATORY	8,049	6,162	125,488	1,397,547	68	60.00
65.00	06500	RESPIRATORY THERAPY	3,374	1,071	20,795	853,705	18	65.00
66.00	06600	PHYSICAL THERAPY	6,338	0	9,241	690,130	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	1,945	210,129	4	67.00
68.00	06800	SPEECH PATHOLOGY	83	83	323	121,646	4	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	88	32,274	391,596	40	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	182	1,426	47,216	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,478	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	03020	ONCOLOGY	6,999	0	2,688	149,713	37	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,078	109,040	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	441	13,484	575,649	18	90.00
91.00	09100	EMERGENCY	9,934	9,665	34,850	1,721,381	56	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	730	681,436	21	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	244,932	75,292	2,617,166	24,147,043	1,115	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	1,297	2,146	59,686	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	0	72,865	8,576,910	153	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	402	286	80,467	3	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	0	417,480	15	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	0	23,520	8	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	89,628	0	194.04
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)	1,829,904	86,509	2,703,810	7,337,071	502,753	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT P HONES)	
		1.00	1.01	2.00	4.00	4.01	
203.00	Unit cost multiplier (Wkst. B, Part I)	6.544347	1.123625	1.004214	0.219707	384.074102	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				21,438	2,699	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000642	2.061879	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	DATA PROCESSING (WORK ORDER S)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	1,722					4.02
4.03	00403	MATERIALS MANAGEMENT	28	6,953,367				4.03
4.04	00404	ADMITTING	0	29,546	172,841,803			4.04
4.05	00405	PATIENT ACCOUNTING	265	42,542	0	172,841,803		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	141	91,865	0	0	-4,423,527	5.00
7.00	00700	OPERATION OF PLANT	22	1,800	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4	606	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,372	0	0	0	9.00
10.00	01000	DIETARY	73	208,382	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	71,049	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	55,710	0	0	0	14.00
15.00	01500	PHARMACY	24	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108	2,733	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	248	180,910	10,385,820	10,385,820	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	54,003	1,535,860	1,535,860	0	31.00
41.00	04100	SUBPROVIDER - IRF	62	16,222	1,473,861	1,473,861	0	41.00
43.00	04300	NURSERY	0	0	564,493	564,493	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159	359,702	28,277,229	28,277,229	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,490	2,526,994	2,526,994	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162	274,774	35,312,731	35,312,731	0	54.00
60.00	06000	LABORATORY	0	994,696	25,445,745	25,445,745	0	60.00
65.00	06500	RESPIRATORY THERAPY	67	102,591	4,943,262	4,943,262	0	65.00
66.00	06600	PHYSICAL THERAPY	24	22,144	3,136,431	3,136,431	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5	26	1,711,813	1,711,813	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	105	604,156	604,156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,541	4,765,320	4,765,320	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,197	150,473	150,473	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,038,781	5,404,580	5,404,580	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,363,015	4,363,015	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,849,257	10,849,257	0	73.00
76.00	03020	ONCOLOGY	15	11,580	633,293	633,293	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	9,055	459,916	459,916	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	74	523,413	11,145,357	11,145,357	0	90.00
91.00	09100	EMERGENCY	0	93,599	17,495,885	17,495,885	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	14,318	1,656,312	1,656,312	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,484	6,243,752	172,841,803	172,841,803	-4,423,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40	13,052	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	198	620,681	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	292	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	72,815	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	2,633	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	142	0	0	0	194.04
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)	3,065,072	418,903	753,015	2,221,663		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,779.948897	0.060245	0.004357	0.012854		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,414,706	54,100	17,140	272,417		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	DATA PROCESSING (WORK ORDER S)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
205.00		Unit cost multiplier (Wkst. B, Part II)	821.548200	0.007780	0.000099	0.001576		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	64,288,453					5.00
7.00	00700	OPERATION OF PLANT	2,938,109	222,778				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	246,280	2,404	500,414			8.00
9.00	00900	HOUSEKEEPING	915,468	1,867	93,365	218,507		9.00
10.00	01000	DIETARY	668,666	3,917	6,675	3,917	6,895	10.00
11.00	01100	CAFETERIA	501,626	4,171	0	4,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,865,071	9,867	0	9,867	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	242,641	1,699	0	1,699	0	14.00
15.00	01500	PHARMACY	4,039,281	2,046	0	2,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,036,875	3,879	0	3,879	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,352,082	27,577	120,785	27,577	4,769	30.00
31.00	03100	INTENSIVE CARE UNIT	1,555,281	7,886	35,190	7,886	935	31.00
41.00	04100	SUBPROVIDER - IRF	1,063,033	6,763	18,187	6,763	1,191	41.00
43.00	04300	NURSERY	254,682	625	0	625	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,290,500	45,761	104,999	45,761	0	50.00
53.00	05300	ANESTHESIOLOGY	80,138	394	0	394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,665,149	16,532	30,368	16,532	0	54.00
60.00	06000	LABORATORY	4,165,661	8,049	0	8,049	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,441,494	3,374	0	3,374	0	65.00
66.00	06600	PHYSICAL THERAPY	1,043,996	6,338	2,276	6,338	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	306,912	1,335	0	1,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	172,818	83	0	83	0	68.00
69.00	06900	ELECTROCARDIOLOGY	872,566	1,080	2,490	1,080	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,076	182	0	182	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,909,372	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,526,381	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	186,726	0	0	0	0	73.00
76.00	03020	ONCOLOGY	313,761	6,999	0	6,999	0	76.00
76.97	07697	CARDIAC REHABILITATION	181,524	2,511	0	2,511	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,097,178	11,516	3,530	11,516	0	90.00
91.00	09100	EMERGENCY	2,800,441	9,934	71,809	9,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,057,469	1,305	0	1,305	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,862,257	188,094	489,674	183,823	6,895	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	191,402	1,297	0	1,297	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,389,849	25,925	10,740	25,925	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	109,407	402	0	402	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	611,234	4,832	0	4,832	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	901,902	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	52,095	2,228	0	2,228	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	122,307	0	0	0	0	194.04
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)	4,423,527	3,140,271	297,113	1,060,210	792,858	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.068807	14.095965	0.593734	4.852064	114.990283	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	206,351	233,937	26,724	25,905	109,669	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003210	1.050090	0.053404	0.118555	15.905584	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	784,774					11.00
13.00	01300	NURSING ADMINISTRATION	23,229	269,965				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,263	0	100			14.00
15.00	01500	PHARMACY	12,587	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,507	0	0	0	172,841,803	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88,119	88,119	0	0	10,385,820	30.00
31.00	03100	INTENSIVE CARE UNIT	36,711	36,711	0	0	1,535,860	31.00
41.00	04100	SUBPROVIDER - IRF	21,508	21,508	0	0	1,473,861	41.00
43.00	04300	NURSERY	6,317	6,317	0	0	564,493	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,080	60,080	0	0	28,277,229	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,526,994	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,283	0	0	0	35,312,731	54.00
60.00	06000	LABORATORY	63,470	0	0	0	25,445,745	60.00
65.00	06500	RESPIRATORY THERAPY	29,186	0	0	0	4,943,262	65.00
66.00	06600	PHYSICAL THERAPY	22,904	0	0	0	3,136,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,144	0	0	0	1,711,813	67.00
68.00	06800	SPEECH PATHOLOGY	3,430	0	0	0	604,156	68.00
69.00	06900	ELECTROCARDIOLOGY	11,322	0	0	0	4,765,320	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,815	0	0	0	150,473	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	100	0	5,404,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,363,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	10,849,257	73.00
76.00	03020	ONCOLOGY	5,919	0	0	0	633,293	76.00
76.97	07697	CARDIAC REHABILITATION	3,775	0	0	0	459,916	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,054	0	0	0	11,145,357	90.00
91.00	09100	EMERGENCY	57,230	57,230	0	0	17,495,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	22,019	0	0	0	1,656,312	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	598,872	269,965	100	100	172,841,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,627	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	136,408	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	2,548	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	33,347	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	4,828	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	5,144	0	0	0	0	194.04
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)	615,173	2,198,570	294,871	4,365,846	1,202,496	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.783886	8.143908	2,948.710000	43,658.460000	0.006957	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 2:52 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	34,073	116,532	44,605	54,135	128,206	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.043418	0.431656	446.050000	541.350000	0.000742	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,653,132		6,653,132	0	6,653,132	30.00
31.00	03100	INTENSIVE CARE UNIT	2,278,561		2,278,561	0	2,278,561	31.00
41.00	04100	SUBPROVIDER - IRF	1,614,347		1,614,347	0	1,614,347	41.00
43.00	04300	NURSERY	344,373		344,373	0	344,373	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,248,246		6,248,246	0	6,248,246	50.00
53.00	05300	ANESTHESIOLOGY	110,698		110,698	0	110,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,614,304		5,614,304	0	5,614,304	54.00
60.00	06000	LABORATORY	4,831,579		4,831,579	0	4,831,579	60.00
65.00	06500	RESPIRATORY THERAPY	1,661,878	0	1,661,878	0	1,661,878	65.00
66.00	06600	PHYSICAL THERAPY	1,277,047	0	1,277,047	0	1,277,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	370,051	0	370,051	0	370,051	67.00
68.00	06800	SPEECH PATHOLOGY	193,174	0	193,174	0	193,174	68.00
69.00	06900	ELECTROCARDIOLOGY	996,574		996,574	0	996,574	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,885		81,885	0	81,885	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,373,221		2,373,221	0	2,373,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,661,760		1,661,760	0	1,661,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,640,898		4,640,898	0	4,640,898	73.00
76.00	03020	ONCOLOGY	477,014		477,014	0	477,014	76.00
76.97	07697	CARDIAC REHABILITATION	247,752		247,752	0	247,752	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,629,332		3,629,332	0	3,629,332	90.00
91.00	09100	EMERGENCY	3,856,652		3,856,652	0	3,856,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,061,884		1,061,884		1,061,884	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,183,740		1,183,740		1,183,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	51,408,102	0	51,408,102	0	51,408,102	200.00
201.00		Less Observation Beds	1,061,884		1,061,884		1,061,884	201.00
202.00		Total (see instructions)	50,346,218	0	50,346,218	0	50,346,218	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,818,465		8,818,465			30.00
31.00	03100	INTENSIVE CARE UNIT	1,535,860		1,535,860			31.00
41.00	04100	SUBPROVIDER - IRF	1,473,861		1,473,861			41.00
43.00	04300	NURSERY	564,493		564,493			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,258,093	23,019,136	28,277,229	0.220964	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	614,480	1,912,514	2,526,994	0.043806	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,435,687	31,877,044	35,312,731	0.158988	0.000000	54.00
60.00	06000	LABORATORY	4,971,948	20,473,797	25,445,745	0.189878	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,375,722	2,567,540	4,943,262	0.336191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	936,085	2,200,346	3,136,431	0.407166	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	953,595	758,218	1,711,813	0.216175	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	307,019	297,137	604,156	0.319742	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	921,477	3,843,843	4,765,320	0.209131	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,932	98,541	150,473	0.544184	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,870,569	2,534,011	5,404,580	0.439113	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,000	4,357,015	4,363,015	0.380874	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,778,463	7,070,794	10,849,257	0.427762	0.000000	73.00
76.00	03020	ONCOLOGY	490	632,803	633,293	0.753228	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1,080	458,836	459,916	0.538690	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,653	11,124,704	11,145,357	0.325636	0.000000	90.00
91.00	09100	EMERGENCY	2,354,962	15,140,923	17,495,885	0.220432	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	505,732	1,061,623	1,567,355	0.677501	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,656,312	1,656,312			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,756,666	131,085,137	172,841,803			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	41,756,666	131,085,137	172,841,803			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.220964	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	54.00
60.00	06000	LABORATORY	0.189878	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	73.00
76.00	03020	ONCOLOGY	0.753228	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.325636	90.00
91.00	09100	EMERGENCY	0.220432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,653,132		6,653,132	0	6,653,132	30.00
31.00	03100	INTENSIVE CARE UNIT	2,278,561		2,278,561	0	2,278,561	31.00
41.00	04100	SUBPROVIDER - IRF	1,614,347		1,614,347	0	1,614,347	41.00
43.00	04300	NURSERY	344,373		344,373	0	344,373	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,248,246		6,248,246	0	6,248,246	50.00
53.00	05300	ANESTHESIOLOGY	110,698		110,698	0	110,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,614,304		5,614,304	0	5,614,304	54.00
60.00	06000	LABORATORY	4,831,579		4,831,579	0	4,831,579	60.00
65.00	06500	RESPIRATORY THERAPY	1,661,878	0	1,661,878	0	1,661,878	65.00
66.00	06600	PHYSICAL THERAPY	1,277,047	0	1,277,047	0	1,277,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	370,051	0	370,051	0	370,051	67.00
68.00	06800	SPEECH PATHOLOGY	193,174	0	193,174	0	193,174	68.00
69.00	06900	ELECTROCARDIOLOGY	996,574		996,574	0	996,574	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,885		81,885	0	81,885	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,373,221		2,373,221	0	2,373,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,661,760		1,661,760	0	1,661,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,640,898		4,640,898	0	4,640,898	73.00
76.00	03020	ONCOLOGY	477,014		477,014	0	477,014	76.00
76.97	07697	CARDIAC REHABILITATION	247,752		247,752	0	247,752	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,629,332		3,629,332	0	3,629,332	90.00
91.00	09100	EMERGENCY	3,856,652		3,856,652	0	3,856,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,061,884		1,061,884		1,061,884	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,183,740		1,183,740		1,183,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	51,408,102	0	51,408,102	0	51,408,102	200.00
201.00		Less Observation Beds	1,061,884		1,061,884		1,061,884	201.00
202.00		Total (see instructions)	50,346,218	0	50,346,218	0	50,346,218	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,818,465		8,818,465			30.00
31.00	03100	INTENSIVE CARE UNIT	1,535,860		1,535,860			31.00
41.00	04100	SUBPROVIDER - IRF	1,473,861		1,473,861			41.00
43.00	04300	NURSERY	564,493		564,493			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,258,093	23,019,136	28,277,229	0.220964	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	614,480	1,912,514	2,526,994	0.043806	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,435,687	31,877,044	35,312,731	0.158988	0.000000	54.00
60.00	06000	LABORATORY	4,971,948	20,473,797	25,445,745	0.189878	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,375,722	2,567,540	4,943,262	0.336191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	936,085	2,200,346	3,136,431	0.407166	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	953,595	758,218	1,711,813	0.216175	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	307,019	297,137	604,156	0.319742	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	921,477	3,843,843	4,765,320	0.209131	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,932	98,541	150,473	0.544184	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,870,569	2,534,011	5,404,580	0.439113	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,000	4,357,015	4,363,015	0.380874	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,778,463	7,070,794	10,849,257	0.427762	0.000000	73.00
76.00	03020	ONCOLOGY	490	632,803	633,293	0.753228	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1,080	458,836	459,916	0.538690	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,653	11,124,704	11,145,357	0.325636	0.000000	90.00
91.00	09100	EMERGENCY	2,354,962	15,140,923	17,495,885	0.220432	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	505,732	1,061,623	1,567,355	0.677501	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,656,312	1,656,312			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,756,666	131,085,137	172,841,803			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	41,756,666	131,085,137	172,841,803			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0001

Period: From 01/01/2015 To 12/31/2015

Worksheet C Part I

Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03020	ONCOLOGY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 1/16/2018 2:52 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	738,757	0	738,757	5,595	132.04	30.00
31.00	INTENSIVE CARE UNIT	138,070		138,070	935	147.67	31.00
41.00	SUBPROVIDER - IRF	162,518	0	162,518	1,191	136.46	41.00
43.00	NURSERY	10,117		10,117	650	15.56	43.00
200.00	Total (lines 30-199)	1,049,462		1,049,462	8,371		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	2,448	323,234	30.00
31.00	INTENSIVE CARE UNIT	256	37,804	31.00
41.00	SUBPROVIDER - IRF	503	68,639	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	3,207	429,677	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 1/16/2018 2:52 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	960,625	28,277,229	0.033972	2,064,798	70,145	50.00
53.00	05300	ANESTHESIOLOGY	22,831	2,526,994	0.009035	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,551	35,312,731	0.018932	1,743,680	33,011	54.00
60.00	06000	LABORATORY	281,428	25,445,745	0.011060	2,489,943	27,539	60.00
65.00	06500	RESPIRATORY THERAPY	122,379	4,943,262	0.024757	1,112,753	27,548	65.00
66.00	06600	PHYSICAL THERAPY	90,587	3,136,431	0.028882	233,368	6,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,890	1,711,813	0.012788	228,211	2,918	67.00
68.00	06800	SPEECH PATHOLOGY	5,773	604,156	0.009555	61,752	590	68.00
69.00	06900	ELECTROCARDIOLOGY	56,424	4,765,320	0.011841	741,863	8,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,754	150,473	0.024948	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	97,965	5,404,580	0.018126	1,691,476	30,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,445	4,363,015	0.003540	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,956	10,849,257	0.007462	1,906,289	14,225	73.00
76.00	03020	ONCOLOGY	72,063	633,293	0.113791	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	23,454	459,916	0.050996	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	206,378	11,145,357	0.018517	15,934	295	90.00
91.00	09100	EMERGENCY	206,728	17,495,885	0.011816	1,063,956	12,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	117,911	1,567,355	0.075229	104,842	7,887	92.00
200.00		Total (lines 50-199)	3,055,142	158,792,812		13,458,865	242,914	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001

Period: From 01/01/2015 To 12/31/2015

Worksheet D Part III

Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,595	0.00	2,448	0	30.00
31.00	03100	INTENSIVE CARE UNIT	935	0.00	256	0	31.00
41.00	04100	SUBPROVIDER - IRF	1,191	0.00	503	0	41.00
43.00	04300	NURSERY	650	0.00	0	0	43.00
200.00		Total (lines 30-199)	8,371		3,207	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,277,229	0.000000	0.000000	2,064,798	50.00
53.00	05300	ANESTHESIOLOGY	0	2,526,994	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,312,731	0.000000	0.000000	1,743,680	54.00
60.00	06000	LABORATORY	0	25,445,745	0.000000	0.000000	2,489,943	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,943,262	0.000000	0.000000	1,112,753	65.00
66.00	06600	PHYSICAL THERAPY	0	3,136,431	0.000000	0.000000	233,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,711,813	0.000000	0.000000	228,211	67.00
68.00	06800	SPEECH PATHOLOGY	0	604,156	0.000000	0.000000	61,752	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,765,320	0.000000	0.000000	741,863	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	150,473	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,404,580	0.000000	0.000000	1,691,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,363,015	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,849,257	0.000000	0.000000	1,906,289	73.00
76.00	03020	ONCOLOGY	0	633,293	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	459,916	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,145,357	0.000000	0.000000	15,934	90.00
91.00	09100	EMERGENCY	0	17,495,885	0.000000	0.000000	1,063,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,567,355	0.000000	0.000000	104,842	92.00
200.00		Total (lines 50-199)	0	158,792,812			13,458,865	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,687,066	0	50.00
53.00	05300	ANESTHESIOLOGY	0	791,746	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,994,580	0	54.00
60.00	06000	LABORATORY	0	1,287,175	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	217,212	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,636	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	196	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,116,123	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	885,653	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	844,044	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,048,240	0	73.00
76.00	03020	ONCOLOGY	0	65,013	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	3,194,632	0	90.00
91.00	09100	EMERGENCY	0	2,638,916	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	296,298	0	92.00
200.00		Total (lines 50-199)	0	28,068,530	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 1/16/2018 2:52 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	0.220964	4,687,066	0	0	1,035,673	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	791,746	0	0	34,683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	7,994,580	0	0	1,271,042	54.00
60.00	06000	LABORATORY	0.189878	1,287,175	867	0	244,406	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	217,212	0	0	73,025	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	1,636	0	0	354	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	196	0	0	63	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	2,116,123	0	0	442,547	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	885,653	0	0	388,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	844,044	0	0	321,474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	3,048,240	0	5,143	1,303,921	73.00
76.00	03020	ONCOLOGY	0.753228	65,013	0	0	48,970	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.325636	3,194,632	459	0	1,040,287	90.00
91.00	09100	EMERGENCY	0.220432	2,638,916	0	0	581,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	296,298	0	0	200,742	92.00
200.00		Subtotal (see instructions)		28,068,530	1,326	5,143	6,987,791	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		28,068,530	1,326	5,143	6,987,791	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	165	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,200	73.00
76.00	03020	ONCOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	149	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)	314	2,200	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	314	2,200	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	960,625	28,277,229	0.033972	9,909	337	50.00
53.00	05300	ANESTHESIOLOGY	22,831	2,526,994	0.009035	1,196	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,551	35,312,731	0.018932	21,372	405	54.00
60.00	06000	LABORATORY	281,428	25,445,745	0.011060	97,736	1,081	60.00
65.00	06500	RESPIRATORY THERAPY	122,379	4,943,262	0.024757	25,021	619	65.00
66.00	06600	PHYSICAL THERAPY	90,587	3,136,431	0.028882	235,640	6,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,890	1,711,813	0.012788	249,626	3,192	67.00
68.00	06800	SPEECH PATHOLOGY	5,773	604,156	0.009555	96,336	920	68.00
69.00	06900	ELECTROCARDIOLOGY	56,424	4,765,320	0.011841	6,604	78	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,754	150,473	0.024948	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	97,965	5,404,580	0.018126	14,706	267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,445	4,363,015	0.003540	4,625	16	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,956	10,849,257	0.007462	59,669	445	73.00
76.00	03020	ONCOLOGY	72,063	633,293	0.113791	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	23,454	459,916	0.050996	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	206,378	11,145,357	0.018517	0	0	90.00
91.00	09100	EMERGENCY	206,728	17,495,885	0.011816	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,567,355	0.000000	19,146	0	92.00
200.00		Total (lines 50-199)	2,937,231	158,792,812		841,586	14,177	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001
Component CCN: 15-T001

Period: From 01/01/2015 To 12/31/2015

Worksheet D Part IV
Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,277,229	0.000000	0.000000	9,909	50.00
53.00	05300	ANESTHESIOLOGY	0	2,526,994	0.000000	0.000000	1,196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,312,731	0.000000	0.000000	21,372	54.00
60.00	06000	LABORATORY	0	25,445,745	0.000000	0.000000	97,736	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,943,262	0.000000	0.000000	25,021	65.00
66.00	06600	PHYSICAL THERAPY	0	3,136,431	0.000000	0.000000	235,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,711,813	0.000000	0.000000	249,626	67.00
68.00	06800	SPEECH PATHOLOGY	0	604,156	0.000000	0.000000	96,336	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,765,320	0.000000	0.000000	6,604	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	150,473	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,404,580	0.000000	0.000000	14,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,363,015	0.000000	0.000000	4,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,849,257	0.000000	0.000000	59,669	73.00
76.00	03020	ONCOLOGY	0	633,293	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	459,916	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,145,357	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	17,495,885	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,567,355	0.000000	0.000000	19,146	92.00
200.00		Total (lines 50-199)	0	158,792,812			841,586	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	60	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00		Total (lines 50-199)	0	60	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | 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	0.220964	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	0	0	0	0	54.00
60.00	06000	LABORATORY	0.189878	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	0	0	205	0	73.00
76.00	03020	ONCOLOGY	0.753228	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.325636	60	0	0	20	90.00
91.00	09100	EMERGENCY	0.220432	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	0	0	0	0	92.00
200.00		Subtotal (see instructions)		60	0	205	20	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		60	0	205	20	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	88	73.00
76.00	03020	ONCOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	88	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	88	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.220964	0	465,550	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	0	45,269	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	0	647,105	0	0	54.00
60.00	06000	LABORATORY	0.189878	0	378,681	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	0	38,128	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	0	26,999	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	0	54,814	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	0	39,900	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	0	42,980	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	0	2,214	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	0	174,617	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	0	176,131	0	0	73.00
76.00	03020	ONCOLOGY	0.753228	0	6,696	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	860	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.325636	0	22,642	0	0	90.00
91.00	09100	EMERGENCY	0.220432	0	670,498	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	2,793,084	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	2,793,084	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	102,870	0	50.00
53.00	05300	ANESTHESIOLOGY	1,983	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,882	0	54.00
60.00	06000	LABORATORY	71,903	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,818	0	65.00
66.00	06600	PHYSICAL THERAPY	10,993	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,849	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,758	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,988	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,205	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,677	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,342	0	73.00
76.00	03020	ONCOLOGY	5,044	0	76.00
76.97	07697	CARDIAC REHABILITATION	463	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	7,373	0	90.00
91.00	09100	EMERGENCY	147,799	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	650,947	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	650,947	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,595	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,595	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,702	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)	2,448	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,653,132	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,653,132	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,653,132	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,189.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,910,966	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)	2,910,966	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 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	2,278,561	935	2,436.96	256	623,862	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)	3,768,536	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,303,364	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)	361,038	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	242,914	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	603,952	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,699,412	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)	893	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,189.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,061,884	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001

Period: From 01/01/2015 To 12/31/2015

Worksheet D-1

Date/Time Prepared: 1/16/2018 2:52 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	738,757	6,653,132	0.111039	1,061,884	117,911	90.00
91.00	Nursing School cost	0	6,653,132	0.000000	1,061,884	0	91.00
92.00	Allied health cost	0	6,653,132	0.000000	1,061,884	0	92.00
93.00	All other Medical Education	0	6,653,132	0.000000	1,061,884	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,191	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,191	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,191	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)	503	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)	1,614,347	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)	1,614,347	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)	1,614,347	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,355.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	681,796	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)	681,796	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	261,417	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	943,213	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)	68,639	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,177	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	82,816	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	860,397	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	162,518	1,614,347	0.100671	0	0	90.00
91.00	Nursing School cost	0	1,614,347	0.000000	0	0	91.00
92.00	Allied health cost	0	1,614,347	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,614,347	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,595	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,595	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,702	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)	132	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)	650	15.00
16.00	Nursery days (title V or XIX only)	18	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,653,132	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,653,132	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,653,132	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,189.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	156,964	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)	156,964	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	344,373	650	529.80	18	9,536	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,278,561	935	2,436.96	26	63,361	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)	144,986	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	374,847	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	893	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,189.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,061,884	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	738,757	6,653,132	0.111039	1,061,884	117,911	90.00
91.00	Nursing School cost	0	6,653,132	0.000000	1,061,884	0	91.00
92.00	Allied health cost	0	6,653,132	0.000000	1,061,884	0	92.00
93.00	All other Medical Education	0	6,653,132	0.000000	1,061,884	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,191	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,191	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,191	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)	31	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)	650	15.00
16.00	Nursery days (title V or XIX only)	18	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)	1,614,347	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)	1,614,347	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)	1,614,347	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,355.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	42,019	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)	42,019	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,947	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	45,966	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	162,518	1,614,347	0.100671	0	0	90.00
91.00	Nursing School cost	0	1,614,347	0.000000	0	0	91.00
92.00	Allied health cost	0	1,614,347	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,614,347	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,236,896		30.00
31.00	03100	INTENSIVE CARE UNIT		518,427		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.220964	2,064,798	456,246	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	1,743,680	277,224	54.00
60.00	06000	LABORATORY	0.189878	2,489,943	472,785	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	1,112,753	374,098	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	233,368	95,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	228,211	49,334	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	61,752	19,745	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	741,863	155,147	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	1,691,476	742,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	1,906,289	815,438	73.00
76.00	03020	ONCOLOGY	0.753228	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.325636	15,934	5,189	90.00
91.00	09100	EMERGENCY	0.220432	1,063,956	234,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	104,842	71,031	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,458,865	3,768,536	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)		13,458,865		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		584,756		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.220964	9,909	2,190	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	1,196	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	21,372	3,398	54.00
60.00	06000	LABORATORY	0.189878	97,736	18,558	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	25,021	8,412	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	235,640	95,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	249,626	53,963	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	96,336	30,803	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	6,604	1,381	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	14,706	6,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	4,625	1,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	59,669	25,524	73.00
76.00	03020	ONCOLOGY	0.753228	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.325636	0	0	90.00
91.00	09100	EMERGENCY	0.220432	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	19,146	12,971	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		841,586	261,417	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)		841,586		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		274,633		30.00
31.00	03100	INTENSIVE CARE UNIT		31,967		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		70,190		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.220964	148,731	32,864	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	21,923	960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	48,913	7,777	54.00
60.00	06000	LABORATORY	0.189878	110,111	20,908	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	33,458	11,248	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	3,583	1,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	3,719	804	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	1,154	369	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	14,717	3,078	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	1,472	801	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	51,865	22,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	79,459	33,990	73.00
76.00	03020	ONCOLOGY	0.753228	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.325636	0	0	90.00
91.00	09100	EMERGENCY	0.220432	36,079	7,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		555,184	144,986	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)		555,184		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		11,298		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.220964	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.043806	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158988	0	0	54.00
60.00	06000	LABORATORY	0.189878	344	65	60.00
65.00	06500	RESPIRATORY THERAPY	0.336191	736	247	65.00
66.00	06600	PHYSICAL THERAPY	0.407166	4,699	1,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.216175	4,651	1,005	67.00
68.00	06800	SPEECH PATHOLOGY	0.319742	863	276	68.00
69.00	06900	ELECTROCARDIOLOGY	0.209131	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544184	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.439113	15	7	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380874	1,139	434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427762	0	0	73.00
76.00	03020	ONCOLOGY	0.753228	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.538690	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.325636	0	0	90.00
91.00	09100	EMERGENCY	0.220432	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677501	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,447	3,947	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)		12,447		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 1/16/2018 2:52 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)	3,845,823	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,139,261	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)	16,582	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	1,581,902	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	83.55	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.65	31.00
32.00	Sum of lines 30 and 31	23.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.82	33.00
34.00	Disproportionate share adjustment (see instructions)	109,922	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 1/16/2018 2:52 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)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000045389	0.000046850	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	347,119	300,126	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	259,626	75,441	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	335,067		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	5,446,655		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)	5,446,655	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	400,258	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		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)	5,846,913	59.00
60.00	Primary payer payments	4,481	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,842,432	61.00
62.00	Deductibles billed to program beneficiaries	665,880	62.00
63.00	Coinsurance billed to program beneficiaries	1,260	63.00
64.00	Allowable bad debts (see instructions)	109,657	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	71,277	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,039	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,246,569	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-9,135	70.93
70.94	HRR adjustment amount (see instructions)	-7,520	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 1/16/2018 2:52 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)		5,229,914	71.00
71.01	Sequestration adjustment (see instructions)		104,598	71.01
72.00	Interim payments		5,112,471	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		12,845	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		63,301	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,845,823	0	3,845,823		3,845,823	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,139,261	0		1,139,261	1,139,261	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	16,582	0	10,702	5,880	16,582	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,581,902	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0882	0.0882	0.0882	0.0882		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	109,922	0	84,801	25,121	109,922	11.00
11.01	Uncompensated care payments	36.00	335,067	0	259,626	75,441	335,067	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,446,655	0	4,200,952	1,245,703	5,446,655	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,446,655	0	4,200,952	1,245,703	5,446,655	15.00
16.00	Payment for inpatient program capital	50.00	400,258	0	308,380	91,878	400,258	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	4,509,332	1,337,581	5,846,913	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	398,975	0	307,616	91,359	398,975	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,283	0	764	519	1,283	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	400,258	0	308,380	91,878	400,258	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.076607	0.087679		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			345,446		345,446	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				117,278	117,278	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,845,823	3,845,823		3,845,823	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,139,261		1,139,261	1,139,261	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	16,582	10,702	5,880	16,582	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,581,902	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0882	0.0882	0.0882		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	109,922	84,801	25,121	109,922	11.00
11.01	Uncompensated care payments	36.00	335,067	259,626	75,441	335,067	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,446,655	4,200,952	1,245,703	5,446,655	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,446,655	4,200,952	1,245,703	5,446,655	15.00
16.00	Payment for inpatient program capital	50.00	400,258	308,899	91,359	400,258	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,509,851	1,337,062	5,846,913	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	398,975	307,616	91,359	398,975	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,283	1,283	0	1,283	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	400,258	308,899	91,359	400,258	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-9,135	-5,527	-3,608	-9,135	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-7,520	-6,153	-1,367	-7,520	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part B Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,514	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,987,791	2.00
3.00	PPS payments	6,018,398	3.00
4.00	Outlier payment (see instructions)	54,785	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,514	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,469	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)	6,469	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)	6,469	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,955	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,514	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	6,073,183	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,306,549	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)	4,769,148	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)	4,769,148	30.00
31.00	Primary payer payments	2,229	31.00
32.00	Subtotal (line 30 minus line 31)	4,766,919	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)	250,038	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	162,525	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	138,253	36.00
37.00	Subtotal (see instructions)	4,929,444	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-44	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,929,488	40.00
40.01	Sequestration adjustment (see instructions)	98,590	40.01
41.00	Interim payments	4,813,392	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	17,506	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | Component CCN: 15-T001

Period: From 01/01/2015 To 12/31/2015

Worksheet E Part B

Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	88	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20	2.00
3.00	PPS payments	107	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	88	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	205	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)	205	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)	205	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	117	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	88	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	107	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	195	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)	195	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	195	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	195	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	195	40.00
40.01	Sequestration adjustment (see instructions)	4	40.01
41.00	Interim payments	191	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part I Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Hospital	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,967,116		4,752,854	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/26/2016	145,355	07/26/2016	60,538	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)		145,355		60,538	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)		5,112,471		4,813,392	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		12,845		17,506	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,125,316		4,830,898	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part I Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Subprovider - IRF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		681,488		191	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/26/2016	5,537		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)		5,537		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)		687,025		191	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		687,025		191	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,792	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,704	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	896	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,637	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	172,841,803	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,169,216	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	348,239	8.00
9.00	Sequestration adjustment amount (see instructions)	6,965	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	341,274	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	362,885	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-21,611	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-3 Part III | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	661,950	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0322	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	40,445	3.00
4.00	Outlier Payments	9,676	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.263014	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	712,071	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	712,071	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	712,071	19.00
20.00	Deductibles	6,300	20.00
21.00	Subtotal (line 19 minus line 20)	705,771	21.00
22.00	Coinsurance	4,725	22.00
23.00	Subtotal (line 21 minus line 22)	701,046	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	701,046	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	701,046	32.00
32.01	Sequestration adjustment (see instructions)	14,021	32.01
33.00	Interim payments	687,025	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	0	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	9,676	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 1/16/2018 2:52 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	374,847		1.00
2.00	Medical and other services		650,947	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	374,847	650,947	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	374,847	650,947	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	376,790		8.00
9.00	Ancillary service charges	555,184	2,793,084	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	931,974	2,793,084	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	931,974	2,793,084	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	557,127	2,142,137	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	374,847	650,947	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	374,847	650,947	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	374,847	650,947	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	374,847	650,947	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	374,847	650,947	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	374,847	650,947	40.00
41.00	Interim payments	374,847	650,947	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | Component CCN: 15-T001

Period: From 01/01/2015 To 12/31/2015

Worksheet E-3 Part VII | Date/Time Prepared: 1/16/2018 2:52 pm

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	45,966		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	45,966	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	45,966	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	11,298		8.00
9.00	Ancillary service charges	12,447	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	23,745	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	23,745	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	22,221	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	23,745	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	23,745	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	22,221	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	23,745	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	23,745	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	23,745	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	23,745	0	40.00
41.00	Interim payments	23,745	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 1/16/2018 2:52 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	4,834,738	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	14,999,276	0	0	0	4.00
5.00	Other receivable	4,860,499	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,878,642	0	0	0	6.00
7.00	Inventory	1,452,912	0	0	0	7.00
8.00	Prepaid expenses	1,354,392	0	0	0	8.00
9.00	Other current assets	24,905,525	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)	49,528,700	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,743,329	0	0	0	12.00
13.00	Land improvements	1,463,185	0	0	0	13.00
14.00	Accumulated depreciation	-974,092	0	0	0	14.00
15.00	Buildings	58,483,192	0	0	0	15.00
16.00	Accumulated depreciation	-30,220,173	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	12,824,093	0	0	0	19.00
20.00	Accumulated depreciation	-9,682,171	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	37,840,031	0	0	0	23.00
24.00	Accumulated depreciation	-30,628,322	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	8,460,938	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	52,310,010	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	41,055,404	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	71,375	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,126,779	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	142,965,489	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,206,767	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,087,969	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,294,736	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,294,736	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	138,670,753				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)	138,670,753	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	142,965,489	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 Date/Time Prepared: 1/16/2018 2:52 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		119,824,083		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-402,082				2.00
3.00	Total (sum of line 1 and line 2)		119,422,001		0		3.00
4.00	TRANSFERS FROM OTHER FUNDS	19,248,752		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)		19,248,752		0		10.00
11.00	Subtotal (line 3 plus line 10)		138,670,753		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)		138,670,753		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	TRANSFERS FROM OTHER FUNDS		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: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/16/2018 2:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,295,504		10,295,504	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,473,861		1,473,861	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,769,365		11,769,365	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,910,533		1,910,533	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,910,533		1,910,533	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,679,898		13,679,898	17.00
18.00	Ancillary services	29,463,391	103,515,539	132,978,930	18.00
19.00	Outpatient services	0	25,112,850	25,112,850	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		1,656,312	1,656,312	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 REVENUE	0	9,510,059	9,510,059	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,143,289	139,794,760	182,938,049	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		72,975,646		29.00
30.00	LOSS ON SALE OF ASSETS	392,485			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)		392,485		36.00
37.00	FISCAL SERVICES EXPENSES	1,000,000			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)		1,000,000		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		72,368,131		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 1/16/2018 2:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	182,938,049	1.00
2.00	Less contractual allowances and discounts on patients' accounts	112,503,604	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,434,445	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,368,131	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,933,686	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-640,357	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,585,213	24.00
24.01	OTHER NONOPERATING REVENUE	11,429	24.01
24.02	RENTAL REVENUE	575,319	24.02
25.00	Total other income (sum of lines 6-24)	1,531,604	25.00
26.00	Total (line 5 plus line 25)	-402,082	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)	-402,082	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510

Period: From 01/01/2015 To 12/31/2015

Worksheet H

Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	195,390	0	64,766	0	104,709	364,865	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	270,473	0	0	0	0	270,473	6.00
7.00	Physical Therapy	125,101	0	0	0	0	125,101	7.00
8.00	Occupational Therapy	85,354	0	0	0	0	85,354	8.00
9.00	Speech Pathology	4,074	0	0	0	0	4,074	9.00
10.00	Medical Social Services	559	0	0	0	0	559	10.00
11.00	Home Health Aide	485	0	0	0	0	485	11.00
12.00	Supplies (see instructions)	0	0	0	0	10,133	10,133	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	681,436	0	64,766	0	114,842	861,044	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	0	364,865	0	364,865	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	270,473	0	270,473	6.00
7.00	Physical Therapy	0	125,101	0	125,101	7.00
8.00	Occupational Therapy	0	85,354	0	85,354	8.00
9.00	Speech Pathology	0	4,074	0	4,074	9.00
10.00	Medical Social Services	0	559	0	559	10.00
11.00	Home Health Aide	0	485	0	485	11.00
12.00	Supplies (see instructions)	0	10,133	0	10,133	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	861,044	0	861,044	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	364,865	0	0	0	0	364,865	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	270,473	0	0	0	0	270,473	6.00
7.00	Physical Therapy	125,101	0	0	0	0	125,101	7.00
8.00	Occupational Therapy	85,354	0	0	0	0	85,354	8.00
9.00	Speech Pathology	4,074	0	0	0	0	4,074	9.00
10.00	Medical Social Services	559	0	0	0	0	559	10.00
11.00	Home Health Aide	485	0	0	0	0	485	11.00
12.00	Supplies (see instructions)	10,133	0	0	0	0	10,133	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	861,044	0	0	0	0	861,044	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	364,865		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	198,892	469,365	6.00
7.00	Physical Therapy	91,993	217,094	7.00
8.00	Occupational Therapy	62,765	148,119	8.00
9.00	Speech Pathology	2,996	7,070	9.00
10.00	Medical Social Services	411	970	10.00
11.00	Home Health Aide	357	842	11.00
12.00	Supplies (see instructions)	7,451	17,584	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		861,044	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0001
HHA CCN: 15-7510
Period: From 01/01/2015 To 12/31/2015
Worksheet H-1 Part II
Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-364,865	496,179	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	270,473	6.00
7.00	Physical Therapy	0	0	0	0	0	125,101	7.00
8.00	Occupational Therapy	0	0	0	0	0	85,354	8.00
9.00	Speech Pathology	0	0	0	0	0	4,074	9.00
10.00	Medical Social Services	0	0	0	0	0	559	10.00
11.00	Home Health Aide	0	0	0	0	0	485	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	10,133	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-364,865	496,179	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		364,865	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.735350	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510

Period: From 01/01/2015 To 12/31/2015

Worksheet H-2 Part I

Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		0	1.00	1.01	2.00	4.00	4.01	
1.00	Administrative and General	0	8,540	0	733	42,929	8,066	1.00
2.00	Skilled Nursing Care	469,365	0	0	0	59,423	0	2.00
3.00	Physical Therapy	217,094	0	0	0	27,486	0	3.00
4.00	Occupational Therapy	148,119	0	0	0	18,753	0	4.00
5.00	Speech Pathology	7,070	0	0	0	895	0	5.00
6.00	Medical Social Services	970	0	0	0	123	0	6.00
7.00	Home Health Aide	842	0	0	0	107	0	7.00
8.00	Supplies (see instructions)	17,584	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	861,044	8,540	0	733	149,716	8,066	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	
		4.02	4.03	4.04	4.05	4A.05	5.00	
1.00	Administrative and General	0	863	7,217	21,290	89,638	6,168	1.00
2.00	Skilled Nursing Care	0	0	0	0	528,788	36,384	2.00
3.00	Physical Therapy	0	0	0	0	244,580	16,829	3.00
4.00	Occupational Therapy	0	0	0	0	166,872	11,482	4.00
5.00	Speech Pathology	0	0	0	0	7,965	548	5.00
6.00	Medical Social Services	0	0	0	0	1,093	75	6.00
7.00	Home Health Aide	0	0	0	0	949	65	7.00
8.00	Supplies (see instructions)	0	0	0	0	17,584	1,210	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	863	7,217	21,290	1,057,469	72,761	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	18,395	0	6,332	0	17,260	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	18,395	0	6,332	0	17,260	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	11,523	149,316	0	149,316	1.00
2.00	Skilled Nursing Care	0	0	0	565,172	0	565,172	2.00
3.00	Physical Therapy	0	0	0	261,409	0	261,409	3.00
4.00	Occupational Therapy	0	0	0	178,354	0	178,354	4.00
5.00	Speech Pathology	0	0	0	8,513	0	8,513	5.00
6.00	Medical Social Services	0	0	0	1,168	0	1,168	6.00
7.00	Home Health Aide	0	0	0	1,014	0	1,014	7.00
8.00	Supplies (see instructions)	0	0	0	18,794	0	18,794	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	11,523	1,183,740	0	1,183,740	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	81,580	646,752	2.00
3.00	Physical Therapy	37,734	299,143	3.00
4.00	Occupational Therapy	25,745	204,099	4.00
5.00	Speech Pathology	1,229	9,742	5.00
6.00	Medical Social Services	169	1,337	6.00
7.00	Home Health Aide	146	1,160	7.00
8.00	Supplies (see instructions)	2,713	21,507	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	149,316	1,183,740	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.144347		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II | Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDER S)	
		1.00	1.01	2.00	4.00	4.01	4.02	
1.00	Administrative and General	1,305	0	730	195,390	21	0	1.00
2.00	Skilled Nursing Care	0	0	0	270,473	0	0	2.00
3.00	Physical Therapy	0	0	0	125,101	0	0	3.00
4.00	Occupational Therapy	0	0	0	85,354	0	0	4.00
5.00	Speech Pathology	0	0	0	4,074	0	0	5.00
6.00	Medical Social Services	0	0	0	559	0	0	6.00
7.00	Home Health Aide	0	0	0	485	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	730	681,436	21	0	20.00
21.00	Total cost to be allocated	8,540	0	733	149,716	8,066	0	21.00
22.00	Unit cost multiplier	6.544061	0.000000	1.004110	0.219707	384.095238	0.000000	22.00

	Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	
		4.03	4.04	4.05	5A	5.00	7.00	
1.00	Administrative and General	14,318	1,656,312	1,656,312	0	89,638	1,305	1.00
2.00	Skilled Nursing Care	0	0	0	0	528,788	0	2.00
3.00	Physical Therapy	0	0	0	0	244,580	0	3.00
4.00	Occupational Therapy	0	0	0	0	166,872	0	4.00
5.00	Speech Pathology	0	0	0	0	7,965	0	5.00
6.00	Medical Social Services	0	0	0	0	1,093	0	6.00
7.00	Home Health Aide	0	0	0	0	949	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	17,584	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	14,318	1,656,312	1,656,312		1,057,469	1,305	20.00
21.00	Total cost to be allocated	863	7,217	21,290		72,761	18,395	21.00
22.00	Unit cost multiplier	0.060274	0.004357	0.012854		0.068807	14.095785	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II | Date/Time Prepared: 1/16/2018 2:52 pm

Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,305	0	22,019	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,305	0	22,019	0	0	20.00
21.00	Total cost to be allocated	0	6,332	0	17,260	0	0	21.00
22.00	Unit cost multiplier	0.000000	4.852107	0.000000	0.783868	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		15.00	16.00	
1.00	Administrative and General	0	1,656,312	1.00
2.00	Skilled Nursing Care	0	0	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	0	0	6.00
7.00	Home Health Aide	0	0	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,656,312	20.00
21.00	Total cost to be allocated	0	11,523	21.00
22.00	Unit cost multiplier	0.000000	0.006957	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	646,752		646,752	3,509	184.31	1.00
2.00	Physical Therapy	3.00	299,143	0	299,143	1,950	153.41	2.00
3.00	Occupational Therapy	4.00	204,099	0	204,099	1,216	167.84	3.00
4.00	Speech Pathology	5.00	9,742	0	9,742	68	143.26	4.00
5.00	Medical Social Services	6.00	1,337		1,337	6	222.83	5.00
6.00	Home Health Aide	7.00	1,160		1,160	30	38.67	6.00
7.00	Total (sum of lines 1-6)		1,162,233	0	1,162,233	6,779		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	169			8.00
8.01	Skilled Nursing Care		26900	0	7			8.01
8.02	Skilled Nursing Care		50032	0	1,484			8.02
9.00	Physical Therapy		18020	0	84			9.00
9.01	Physical Therapy		26900	0	7			9.01
9.02	Physical Therapy		50032	0	930			9.02
10.00	Occupational Therapy		18020	0	84			10.00
10.01	Occupational Therapy		26900	0	1			10.01
10.02	Occupational Therapy		50032	0	655			10.02
11.00	Speech Pathology		18020	0	9			11.00
11.01	Speech Pathology		26900	0	0			11.01
11.02	Speech Pathology		50032	0	9			11.02
12.00	Medical Social Services		18020	0	0			12.00
12.01	Medical Social Services		26900	0	0			12.01
12.02	Medical Social Services		50032	0	4			12.02
13.00	Home Health Aide		18020	0	0			13.00
13.01	Home Health Aide		26900	0	0			13.01
13.02	Home Health Aide		50032	0	30			13.02
14.00	Total (sum of lines 8-13)			0	3,473			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	21,507	0	21,507	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,660		0	305,955		1.00
2.00	Physical Therapy	0	1,021		0	156,632		2.00
3.00	Occupational Therapy	0	740		0	124,202		3.00
4.00	Speech Pathology	0	18		0	2,579		4.00
5.00	Medical Social Services	0	4		0	891		5.00
6.00	Home Health Aide	0	30		0	1,160		6.00
7.00	Total (sum of lines 1-6)	0	3,473		0	591,419		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	305,955	1.00
2.00	Physical Therapy	156,632	2.00
3.00	Occupational Therapy	124,202	3.00
4.00	Speech Pathology	2,579	4.00
5.00	Medical Social Services	891	5.00
6.00	Home Health Aide	1,160	6.00
7.00	Total (sum of lines 1-6)	591,419	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part II | Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.407166	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.216175	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.319742	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.439113	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.427762	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 HHA CCN: 15-7510	Period: From 01/01/2015 To 12/31/2015	Worksheet H-4 Part I-II Date/Time Prepared: 1/16/2018 2:52 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	644,065	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	5,834	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	4,747	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,378	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	223	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	27	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	656,274	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	656,274	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	656,274	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	656,274	29.00
30.00	OTHER	0	-1,614	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	654,660	31.00
31.01	Sequestration adjustment (see instructions)	0	13,093	31.01
32.00	Interim payments (see instructions)	0	641,567	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0001 HHA CCN: 15-7510	Period: From 01/01/2015 To 12/31/2015	Worksheet H-5 Date/Time Prepared: 1/16/2018 2:52 pm
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		641,567	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			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			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. H-4, Part II, column as appropriate, line 32)		0		641,567	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		641,567	7.00

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

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0001 | Period: From 01/01/2015 To 12/31/2015 | Worksheet L Parts I-III Date/Time Prepared: 1/16/2018 2:52 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	398,975	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,283	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)	15.78	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)	400,258	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