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: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 12:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 12:13 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH FRANKFORT HOSPITAL (15-1316) for the cost reporting period beginning 06/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

CHIEF FINANCIAL OFFICER
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	1,463,331	1,848,348	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	465,766	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	1,929,097	1,848,348	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:			1.00
2.00	City: FRANKFORT	State: IN	Zip Code: 46041	County: CLINTON	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	IU HEALTH FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:13 pm

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 12:13 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:13 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:13 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	16,792	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 12:13 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	09/29/2017	146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	09/28/2017	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	27	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 12:13 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	06/01/2017	1.00

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		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)	Y	04/18/2018	Y	04/18/2018	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: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 12:13 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 12:13 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.	GOVERNMENT PROGRAMS DIRECTOR		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: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 12:13 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	25	5,350	12,408.00	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)		25	5,350	12,408.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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)		25	5,350	12,408.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 12:13 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)	387	5	517			1.00
2.00	HMO and other (see instructions)	65	30				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	122	0	122			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	509	5	662			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	0			13.00
14.00	Total (see instructions)	509	5	662	0.00	51.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	51.26	27.00
28.00	Observation Bed Days		5	222			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

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	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	130	2	183	1.00
2.00	HMO and other (see instructions)			22	11		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	130	2	183	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/29/2018 12:13 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)	0.629775	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	932,046	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,074,742	6.00
7.00	Medicaid cost (line 1 times line 6)	3,825,721	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)	2,893,675	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)	2,893,675	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,040,277	92,140	1,132,417	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	655,140	92,140	747,280	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	655,140	92,140	747,280	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,350,115	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	36,062	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	55,479	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,294,636	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	834,746	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,582,026	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,475,701	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 12:13 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		11,124	11,124	574,509	585,633	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	476,231	476,231	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB		0	0	16,500	16,500	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,727	14,905	22,632	509,152	531,784	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	504,195	2,038,788	2,542,983	-354,373	2,188,610	5.00
7.00	00700	OPERATION OF PLANT	177,700	3,989,843	4,167,543	-3,957,786	209,757	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	3,318,849	3,318,849	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	26,461	26,461	8.00
9.00	00900	HOUSEKEEPING	133,415	121,803	255,218	-44,911	210,307	9.00
10.00	01000	DIETARY	101,424	158,005	259,429	-173,191	86,238	10.00
11.00	01100	CAFETERIA	0	0	0	133,387	133,387	11.00
13.00	01300	NURSING ADMINISTRATION	368,761	80,286	449,047	-42,787	406,260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	55,697	55,697	199,436	255,133	14.00
15.00	01500	PHARMACY	225,463	187,888	413,351	-139,733	273,618	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	492,862	509,083	1,001,945	-136,981	864,964	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	182,066	658,812	840,878	-165,125	675,753	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,751	136,734	485,485	-93,168	392,317	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,560	377,124	384,684	-150	384,534	60.00
66.00	06600	PHYSICAL THERAPY	488	269,455	269,943	-4,082	265,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116,760	116,760	0	116,760	67.00
68.00	06800	SPEECH PATHOLOGY	40,068	14,908	54,976	-11,193	43,783	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,369	18,369	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	116,326	116,326	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	24,980	24,980	73.01
76.00	03020	CARDIOPULMONARY	220,359	133,519	353,878	-57,655	296,223	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,000	5,000	-5,000	0	90.00
91.00	09100	EMERGENCY	538,572	1,622,811	2,161,383	-211,565	1,949,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,349,411	10,502,545	13,851,956	16,500	13,868,456	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	97,787	97,787	-16,500	81,287	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	3,349,411	10,600,332	13,949,743	0	13,949,743	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 12:13 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	51,168	636,801		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	106,884	583,115		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB	1,634	18,134		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,065	693,849		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,452,081	5,640,691		5.00
7.00	00700	OPERATION OF PLANT	48,244	258,001		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	-871,198	2,447,651		7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,461		8.00
9.00	00900	HOUSEKEEPING	11,319	221,626		9.00
10.00	01000	DIETARY	0	86,238		10.00
11.00	01100	CAFETERIA	-32,894	100,493		11.00
13.00	01300	NURSING ADMINISTRATION	0	406,260		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36,070	291,203		14.00
15.00	01500	PHARMACY	247,016	520,634		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-246,835	618,129		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-155,716	520,037		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	392,317		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	384,534		60.00
66.00	06600	PHYSICAL THERAPY	0	265,861		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116,760		67.00
68.00	06800	SPEECH PATHOLOGY	0	43,783		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,369		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	116,326		73.00
73.01	07301	ONCOLOGY DRUGS	0	24,980		73.01
76.00	03020	CARDIOPULMONARY	0	296,223		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-196,443	1,753,375		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,613,395	16,481,851		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	81,287		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	LEASED SPACE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	2,613,395	16,563,138		200.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:13 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	61,599	71,788		1.00
	0		61,599	71,788		
	B - DRUGS					
1.00	PHARMACY	15.00	0	19,732		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	116,326		2.00
3.00	ONCOLOGY DRUGS	73.01	0	24,980		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	161,038		
	C - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	215,707		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	18,369		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	TOTALS		0	234,076		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	26,461		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	26,461		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	476,231		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	TOTALS		0	476,231		
	F - OTHER CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	583,333		1.00
2.00	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	15,000		2.00
	TOTALS		0	598,333		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	3,318,849		1.00
	TOTALS		0	3,318,849		
	H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	509,152		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	509,152		
	I - HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	897		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:13 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	897		
	J - NONCAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,824		1.00
	TOTALS		0	8,824		
	K - MOB MAINTENANCE AND RENT					
1.00	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	1,500		1.00
	TOTALS		0	1,500		
	L - ONCOLOGY					
1.00	OPERATING ROOM	50.00	0	5,000		1.00
	TOTALS		0	5,000		
500.00	Grand Total: Increases		61,599	5,412,149		500.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	61,599	71,788	0		1.00
	0		61,599	71,788			
	B - DRUGS						
1.00	PHARMACY	15.00	0	131,450	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,777	0		2.00
3.00	OPERATING ROOM	50.00	0	217	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,303	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	94	0		5.00
6.00	CARDIOPULMONARY	76.00	0	974	0		6.00
7.00	EMERGENCY	91.00	0	15,223	0		7.00
	TOTALS		0	161,038			
	C - MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54	0		1.00
2.00	OPERATION OF PLANT	7.00	0	206	0		2.00
3.00	HOUSEKEEPING	9.00	0	3,412	0		3.00
4.00	DIETARY	10.00	0	10	0		4.00
5.00	PHARMACY	15.00	0	4,559	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	34,165	0		6.00
7.00	OPERATING ROOM	50.00	0	56,372	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,067	0		8.00
9.00	LABORATORY	60.00	0	150	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	3,677	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	3,202	0		11.00
12.00	CARDIOPULMONARY	76.00	0	6,979	0		12.00
13.00	EMERGENCY	91.00	0	107,223	0		13.00
	TOTALS		0	234,076			
	D - LAUNDRY						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,271	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,220	0		2.00
3.00	OPERATING ROOM	50.00	0	458	0		3.00
4.00	EMERGENCY	91.00	0	5,512	0		4.00
	TOTALS		0	26,461			
	E - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	323,120	9		1.00
2.00	OPERATION OF PLANT	7.00	0	9,384	0		2.00
3.00	DIETARY	10.00	0	2,425	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	13,950	0		4.00
5.00	OPERATING ROOM	50.00	0	78,744	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,101	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	105	0		7.00
8.00	CARDIOPULMONARY	76.00	0	26,847	0		8.00
9.00	EMERGENCY	91.00	0	1,555	0		9.00
	TOTALS		0	476,231			
	F - OTHER CAPITAL						
1.00	OPERATION OF PLANT	7.00	0	583,333	10		1.00
2.00	MOB	192.02	0	15,000	13		2.00
	TOTALS		0	598,333			
	G - OPERATION OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	3,318,849	0		1.00
	TOTALS		0	3,318,849			
	H - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,023	0		1.00
2.00	OPERATION OF PLANT	7.00	0	46,014	0		2.00
3.00	HOUSEKEEPING	9.00	0	42,396	0		3.00
4.00	DIETARY	10.00	0	37,313	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	42,787	0		5.00
6.00	PHARMACY	15.00	0	23,165	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	81,808	0		7.00
8.00	OPERATING ROOM	50.00	0	34,127	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,621	0		9.00
10.00	SPEECH PATHOLOGY	68.00	0	7,991	0		10.00
11.00	CARDIOPULMONARY	76.00	0	22,855	0		11.00
12.00	EMERGENCY	91.00	0	82,052	0		12.00
	TOTALS		0	509,152			
	I - HOUSEKEEPING						
1.00	DIETARY	10.00	0	56	0		1.00
2.00	PHARMACY	15.00	0	291	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	61	0		3.00
4.00	OPERATING ROOM	50.00	0	207	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	76	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	206	0		6.00
	TOTALS		0	897			

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 12:13 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - NONCAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,824	12		1.00
	TOTALS		0	8,824			
	K - MOB MAINTENANCE AND RENT						
1.00	MOB	192.02	0	1,500	10		1.00
	TOTALS		0	1,500			
	L - ONCOLOGY						
1.00	CLINIC	90.00	0	5,000	0		1.00
	TOTALS		0	5,000			
500.00	Grand Total: Decreases		61,599	5,412,149			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2018 12:13 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	1,980,094	0	1,980,094	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	3,372,166	0	3,372,166	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	5,352,260	0	5,352,260	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	5,352,260	0	5,352,260	0	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	1,980,094	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	3,372,166	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	5,352,260	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	5,352,260	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/29/2018 12:13 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	0	0	0	11,124	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	11,124	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	11,124	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	11,124	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2018 12:13 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	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	5,315,770	0	5,315,770	0.993182	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	36,490	0	36,490	0.006818	0	1.02
3.00	Total (sum of lines 1-2)	5,352,260	0	5,352,260	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	0	583,333	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	513,566	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	0	1,634	1,500	1.02
3.00	Total (sum of lines 1-2)	0	0	0	515,200	584,833	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	51,168	2,300	0	0	636,801	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	69,549	0	0	0	583,115	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	15,000	0	18,134	1.02
3.00	Total (sum of lines 1-2)	120,717	2,300	15,000	0	1,238,050	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 12:13 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)	B	1,282	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-483,148			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	7,973,913			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-35,751	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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 - HOSPITAL	A	25,956	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - MOB	A	1,634	CAP REL COSTS-BLDG & FIXT - MOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 12:13 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CRNA COSTS	A	-174,288	OPERATING ROOM	50.00	0	33.00
33.01	EMPLOYEE BENEFITS	A	-509,286	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MEDICAID HAF FEES	A	-177,653	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MARKETING	A	-229	OPERATING ROOM	50.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-7	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-11,700	OPERATING ROOM	50.00	0	33.05
33.06	ACCRUED PTO	A	-3,365	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	ACCRUED PTO	A	-201,023	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	TELEPHONE EXP	A	-13,696	OPERATION OF PLANT	7.00	0	33.08
33.09	START UP COSTS (HOME OFFICE OFFSET)	A	-3,239,968	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	AMORTIZED START UP COSTS	A	377,996	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CAPITALIZED ASSETS PREVIOUSLY EXP	A	-928,651	OPERATION OF PLANT - HOSPITAL	7.01	0	33.11
33.12	DEPRECIATION ON CAPITALIZED ASSETS	A	11,379	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,613,395				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2018 12:13 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	23,133	0	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE	38,566	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	622,829	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4,072,072	966,377	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	START UP COSTS	3,239,968	0	3.02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY	26,753	0	3.03
4.00	1.01	CAP REL COSTS-BLDG & FIXT -	RELATED PARTY	30,983	0	4.00
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	51,887	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	347,073	0	4.03
4.04	7.00	OPERATION OF PLANT	RELATED PARTY	61,940	0	4.04
4.05	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	57,453	0	4.05
4.06	9.00	HOUSEKEEPING	RELATED PARTY	11,319	0	4.06
4.07	11.00	CAFETERIA	RELATED PARTY	2,857	0	4.07
4.08	14.00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	36,070	0	4.08
4.09	15.00	PHARMACY	RELATED PARTY	247,016	0	4.09
4.10	30.00	ADULTS & PEDIATRICS	RELATED PARTY	268,075	257,455	4.10
4.11	50.00	OPERATING ROOM	RELATED PARTY	204,789	174,288	4.11
4.12	60.00	LABORATORY	RELATED PARTY	364,666	364,666	4.12
4.13	91.00	EMERGENCY	RELATED PARTY	29,250	0	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,736,699	1,762,786	5.00

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

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

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

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

6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/29/2018 12:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	23,133	11		1.00
2.00	38,566	11		2.00
3.00	622,829	0		3.00
3.01	3,105,695	0		3.01
3.02	3,239,968	0		3.02
3.03	26,753	11		3.03
4.00	30,983	11		4.00
4.02	51,887	0		4.02
4.03	347,073	0		4.03
4.04	61,940	0		4.04
4.05	57,453	0		4.05
4.06	11,319	0		4.06
4.07	2,857	0		4.07
4.08	36,070	0		4.08
4.09	247,016	0		4.09
4.10	10,620	0		4.10
4.11	30,501	0		4.11
4.12	0	0		4.12
4.13	29,250	0		4.13
5.00	7,973,913			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 12:13 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	91.00	EMERGENCY	1,085,573	225,693	859,880	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	257,455	257,455	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,343,028	483,148	859,880		0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	225,693		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	257,455		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	483,148		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2018 12:13 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					28	1.00
2.00	Line 1 multiplied by 15 hours per week					420	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					173	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					124	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.35	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,356.03	874.03	601.84	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.04	60.78	22.84	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.52	40.52	30.39			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					190,933	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					53,124	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					244,057	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					13,746	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					257,803	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					257,803	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					7,010	24.00
25.00	Assistants (line 4 times column 3, line 11)					3,768	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,778	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,589	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,367	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					12,367	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2018 12:13 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.04	60.78	22.84	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	257,803		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,367		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	270,170		63.00
64.00	Total cost of outside supplier services (from your records)	257,519		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	10,778		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,589		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,367		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,589		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,589		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2018 12:13 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		28	1.00
2.00	Line 1 multiplied by 15 hours per week		420	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		113	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		141	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.35	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	845.63	804.40	307.44	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.82	57.62	22.84	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.41	38.41	28.81			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	64,961	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	46,350	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	111,311	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	7,022	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	118,333	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	118,333	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,340	24.00
25.00	Assistants (line 4 times column 3, line 11)	4,062	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,402	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,359	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	9,761	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	9,761	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2018 12:13 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.82	57.62	22.84	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		118,333	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		9,761	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		128,094	63.00
64.00	Total cost of outside supplier services (from your records)		116,760	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		8,402	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,359	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		9,761	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,359	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,359	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - MOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	636,801	636,801				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	583,115	0	583,115			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB	18,134	0	0	18,134		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	693,849	0	0	0	693,849	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,640,691	63,283	78,521	0	104,689	5.00
7.00	00700	OPERATION OF PLANT	258,001	7,992	9,916	0	36,897	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,447,651	114,850	142,506	0	0	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	26,461	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	221,626	18,014	22,351	0	27,702	9.00
10.00	01000	DIETARY	86,238	11,978	14,863	0	8,269	10.00
11.00	01100	CAFETERIA	100,493	18,530	22,992	0	12,790	11.00
13.00	01300	NURSING ADMINISTRATION	406,260	1,223	1,517	0	76,568	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	291,203	6,686	8,296	0	0	14.00
15.00	01500	PHARMACY	520,634	9,362	11,616	0	46,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	618,129	92,689	115,007	0	102,335	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	520,037	10,119	12,555	0	37,803	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	392,317	22,042	27,349	0	72,413	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	384,534	18,590	23,067	0	1,570	60.00
66.00	06600	PHYSICAL THERAPY	265,861	12,011	14,903	0	101	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,760	5,708	7,082	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,783	2,990	3,710	0	8,320	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,369	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	116,326	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	24,980	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	296,223	11,088	13,758	0	45,754	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,753,375	20,459	25,385	0	111,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,481,851	447,614	555,394	0	693,849	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	81,287	166,845	0	18,134	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	22,342	27,721	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,563,138	636,801	583,115	18,134	693,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,887,184	5,887,184				5.00
7.00	00700	OPERATION OF PLANT	312,806	172,495	485,301			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,705,007	1,491,662	98,558	4,295,227		7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	26,461	14,592	0	0	0	8.00
9.00	00900	HOUSEKEEPING	289,693	159,749	15,458	272,602	0	9.00
10.00	01000	DIETARY	121,348	66,917	10,279	181,269	0	10.00
11.00	01100	CAFETERIA	154,805	85,366	15,902	280,423	0	11.00
13.00	01300	NURSING ADMINISTRATION	485,568	267,763	1,049	18,504	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	306,185	168,844	5,737	101,178	0	14.00
15.00	01500	PHARMACY	588,426	324,483	8,034	141,678	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	928,160	511,827	79,540	1,402,672	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	580,514	320,120	8,683	153,129	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	514,121	283,508	18,915	333,560	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	427,761	235,886	15,953	281,330	0	60.00
66.00	06600	PHYSICAL THERAPY	292,876	161,504	10,307	181,758	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,550	71,439	4,898	86,375	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,803	32,427	2,566	45,247	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,369	10,129	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	116,326	64,147	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	24,980	13,775	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	366,823	202,282	9,515	167,793	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,911,043	1,053,831	17,557	309,610	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,246,809	5,712,746	322,951	3,957,128	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	266,266	146,831	143,178	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	50,063	27,607	19,172	338,099	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,563,138	5,887,184	485,301	4,295,227	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	41,053					8.00
9.00	00900	HOUSEKEEPING	0	737,502				9.00
10.00	01000	DIETARY	0	24,656	404,469			10.00
11.00	01100	CAFETERIA	0	38,143	0	574,639		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,517	0	60,440	835,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,762	0	0	0	14.00
15.00	01500	PHARMACY	0	19,271	0	33,288	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,053	190,788	404,469	117,505	375,432	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,828	0	44,026	73,100	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,370	0	74,860	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	38,266	0	58,599	0	60.00
66.00	06600	PHYSICAL THERAPY	0	24,722	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,749	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,154	0	6,596	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0	22,823	0	46,634	519	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	42,113	0	132,691	386,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,053	501,162	404,469	574,639	835,841	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	190,352	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	45,988	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,053	737,502	404,469	574,639	835,841	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
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	595,706					14.00
15.00	01500	PHARMACY	11,788	1,126,968				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,478	19,434	0	4,153,358	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,931	1,295	0	1,318,626	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,585	10,063	0	1,315,982	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	388	0	0	1,058,183	0	60.00
66.00	06600	PHYSICAL THERAPY	9,507	0	0	680,674	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	304,011	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,279	0	0	160,072	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,495	0	0	75,993	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	814,061	0	994,534	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	174,813	0	213,568	0	73.01
76.00	03020	CARDIOPULMONARY	17,882	770	0	835,041	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	265,373	106,532	0	4,225,540	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	595,706	1,126,968	0	15,335,582	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	746,627	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	480,929	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	595,706	1,126,968	0	16,563,138	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - MOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,153,358		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,318,626		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315,982		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
56.00	03630	ULTRA SOUND	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	1,058,183		60.00
66.00	06600	PHYSICAL THERAPY	680,674		66.00
67.00	06700	OCCUPATIONAL THERAPY	304,011		67.00
68.00	06800	SPEECH PATHOLOGY	160,072		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,993		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,534		73.00
73.01	07301	ONCOLOGY DRUGS	213,568		73.01
76.00	03020	CARDIOPULMONARY	835,041		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	4,225,540		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,335,582		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.02	19202	MOB	746,627		192.02
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	LEASED SPACE	480,929		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	16,563,138		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - MOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	63,283	78,521	0	141,804	5.00
7.00	00700	OPERATION OF PLANT	0	7,992	9,916	0	17,908	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	114,850	142,506	0	257,356	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	18,014	22,351	0	40,365	9.00
10.00	01000	DIETARY	0	11,978	14,863	0	26,841	10.00
11.00	01100	CAFETERIA	0	18,530	22,992	0	41,522	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,223	1,517	0	2,740	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,686	8,296	0	14,982	14.00
15.00	01500	PHARMACY	0	9,362	11,616	0	20,978	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	92,689	115,007	0	207,696	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,119	12,555	0	22,674	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,042	27,349	0	49,391	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	18,590	23,067	0	41,657	60.00
66.00	06600	PHYSICAL THERAPY	0	12,011	14,903	0	26,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,708	7,082	0	12,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,990	3,710	0	6,700	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0	11,088	13,758	0	24,846	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	20,459	25,385	0	45,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	447,614	555,394	0	1,003,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	166,845	0	18,134	184,979	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	22,342	27,721	0	50,063	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	636,801	583,115	18,134	1,238,050	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	141,804				5.00
7.00	00700	OPERATION OF PLANT	0	4,155	22,063			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	35,926	4,481	297,763		7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	351	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	3,848	703	18,898	0	9.00
10.00	01000	DIETARY	0	1,612	467	12,566	0	10.00
11.00	01100	CAFETERIA	0	2,056	723	19,440	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,450	48	1,283	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,067	261	7,014	0	14.00
15.00	01500	PHARMACY	0	7,816	365	9,822	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,329	3,616	97,239	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,711	395	10,616	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,829	860	23,124	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	5,682	725	19,503	0	60.00
66.00	06600	PHYSICAL THERAPY	0	3,890	469	12,600	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,721	223	5,988	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	781	117	3,137	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	244	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	1,545	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	332	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0	4,873	433	11,632	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	25,384	798	21,463	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	137,602	14,684	274,325	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	3,537	6,507	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	665	872	23,438	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	141,804	22,063	297,763	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	351					8.00
9.00	00900	HOUSEKEEPING	0	63,814				9.00
10.00	01000	DIETARY	0	2,133	43,619			10.00
11.00	01100	CAFETERIA	0	3,300	0	67,041		11.00
13.00	01300	NURSING ADMINISTRATION	0	218	0	7,051	17,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,191	0	0	0	14.00
15.00	01500	PHARMACY	0	1,667	0	3,884	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	351	16,508	43,619	13,709	7,991	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,802	0	5,136	1,556	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,926	0	8,734	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	3,311	0	6,837	0	60.00
66.00	06600	PHYSICAL THERAPY	0	2,139	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,017	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	533	0	770	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0	1,975	0	5,441	11	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,644	0	15,479	8,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351	43,364	43,619	67,041	17,790	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	16,471	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	3,979	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	351	63,814	43,619	67,041	17,790	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
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	27,515					14.00
15.00	01500	PHARMACY	544	45,076				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,810	777	0	407,645	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,401	52	0	55,343	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,644	403	0	94,911	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	18	0	0	77,733	0	60.00
66.00	06600	PHYSICAL THERAPY	439	0	0	46,451	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	21,739	0	67.00
68.00	06800	SPEECH PATHOLOGY	382	0	0	12,420	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,194	0	0	2,438	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	32,560	0	34,105	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	6,992	0	7,324	0	73.01
76.00	03020	CARDIOPULMONARY	826	31	0	50,068	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	12,257	4,261	0	137,362	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,515	45,076	0	947,539	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	211,494	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	79,017	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,515	45,076	0	1,238,050	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - MOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	407,645		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	55,343		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,911		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
56.00	03630	ULTRA SOUND	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	77,733		60.00
66.00	06600	PHYSICAL THERAPY	46,451		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,739		67.00
68.00	06800	SPEECH PATHOLOGY	12,420		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,438		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,105		73.00
73.01	07301	ONCOLOGY DRUGS	7,324		73.01
76.00	03020	CARDIOPULMONARY	50,068		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	137,362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	947,539		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.02	19202	MOB	211,494		192.02
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	LEASED SPACE	79,017		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,238,050		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - MOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	138,011					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	101,851				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB	0	0	36,160			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	3,341,684		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,715	13,715	0	504,195	-5,887,184	5.00
7.00	00700	OPERATION OF PLANT	1,732	1,732	0	177,700	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	24,891	24,891	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,904	3,904	0	133,415	0	9.00
10.00	01000	DIETARY	2,596	2,596	0	39,825	0	10.00
11.00	01100	CAFETERIA	4,016	4,016	0	61,599	0	11.00
13.00	01300	NURSING ADMINISTRATION	265	265	0	368,761	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,449	1,449	0	0	0	14.00
15.00	01500	PHARMACY	2,029	2,029	0	225,463	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,088	20,088	0	492,862	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,193	2,193	0	182,066	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,777	4,777	0	348,751	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,029	4,029	0	7,560	0	60.00
66.00	06600	PHYSICAL THERAPY	2,603	2,603	0	488	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,237	1,237	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	648	648	0	40,068	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	2,403	2,403	0	220,359	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,434	4,434	0	538,572	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,009	97,009	0	3,341,684	-5,887,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	36,160	0	36,160	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	4,842	4,842	0	0	0	194.00
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)	636,801	583,115	18,134	693,849		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.614132	5.725177	0.501493	0.207635		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - MOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,675,954					5.00
7.00	00700	OPERATION OF PLANT	312,806	122,564				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,705,007	24,891	61,513			7.01
7.02	00702	OPERATION OF PLANT - MOB	0	0	0	36,160		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	26,461	0	0	0	662	8.00
9.00	00900	HOUSEKEEPING	289,693	3,904	3,904	0	0	9.00
10.00	01000	DIETARY	121,348	2,596	2,596	0	0	10.00
11.00	01100	CAFETERIA	154,805	4,016	4,016	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	485,568	265	265	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	306,185	1,449	1,449	0	0	14.00
15.00	01500	PHARMACY	588,426	2,029	2,029	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	928,160	20,088	20,088	0	662	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	580,514	2,193	2,193	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	514,121	4,777	4,777	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	427,761	4,029	4,029	0	0	60.00
66.00	06600	PHYSICAL THERAPY	292,876	2,603	2,603	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,550	1,237	1,237	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,803	648	648	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,369	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	116,326	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	24,980	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	366,823	2,403	2,403	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,911,043	4,434	4,434	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,359,625	81,562	56,671	0	662	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	266,266	36,160	0	36,160	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	50,063	4,842	4,842	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,887,184	485,301	4,295,227	0	41,053	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.551443	3.959572	69.826329	0.000000	62.013595	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	141,804	22,063	297,763	0	351	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013283	0.180012	4.840652	0.000000	0.530211	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - MOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	77,651					9.00
10.00	01000	DIETARY	2,596	662				10.00
11.00	01100	CAFETERIA	4,016	0	3,746			11.00
13.00	01300	NURSING ADMINISTRATION	265	0	394	32,233		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,449	0	0	0	230,395	14.00
15.00	01500	PHARMACY	2,029	0	217	0	4,559	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,088	662	766	14,478	31,899	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,193	0	287	2,819	45,224	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,777	0	488	0	13,763	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,029	0	382	0	150	60.00
66.00	06600	PHYSICAL THERAPY	2,603	0	0	0	3,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,237	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	648	0	43	0	3,202	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,369	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
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	2,403	0	304	20	6,916	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,434	0	865	14,916	102,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,767	662	3,746	32,233	230,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	MOB	20,042	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	LEASED SPACE	4,842	0	0	0	0	194.00
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)	737,502	404,469	574,639	835,841	595,706	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.497650	610.980363	153.400694	25.931220	2.585586	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,814	43,619	67,041	17,790	27,515	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.821805	65.889728	17.896690	0.551919	0.119425	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 12:13 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			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 - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - MOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - MOB				7.02
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	161,039			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,777	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	185	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,438	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,326	0		73.00
73.01	07301	ONCOLOGY DRUGS	24,980	0		73.01
76.00	03020	CARDIOPULMONARY	110	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	15,223	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,039	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	LEASED SPACE	0	0		194.00
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)	1,126,968	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.998106	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,076	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.279907	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,153,358		4,153,358	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,318,626		1,318,626	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315,982		1,315,982	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	03630	ULTRA SOUND	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,058,183		1,058,183	0	0	60.00
66.00	06600	PHYSICAL THERAPY	680,674	0	680,674	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,011	0	304,011	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	160,072	0	160,072	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,993		75,993	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,534		994,534	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	213,568		213,568	0	0	73.01
76.00	03020	CARDIOPULMONARY	835,041		835,041	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	4,225,540		4,225,540	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,069,982		1,069,982		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	16,405,564	0	16,405,564	0	0	200.00
201.00		Less Observation Beds	1,069,982		1,069,982		0	201.00
202.00		Total (see instructions)	15,335,582	0	15,335,582	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,108,918		1,108,918			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,433	671,038	673,471	1.957955	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,355	4,144,773	4,293,128	0.306532	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	142,942	1,998,896	2,141,838	0.494054	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	182,237	825,194	1,007,431	0.675653	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,520	334,300	479,820	0.633594	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	64,650	70,772	135,422	1.182024	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,399	4,399	17.275063	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	449,176	1,046,015	1,495,191	0.665155	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	120,668	120,668	1.769881	0.000000	73.01
76.00	03020	CARDIOPULMONARY	97,012	889,844	986,856	0.846163	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	130,384	10,959,987	11,090,371	0.381010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,480	801,893	813,373	1.315487	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	2,483,107	21,867,779	24,350,886			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,483,107	21,867,779	24,350,886			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	03630	ULTRA SOUND	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03020	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,153,358		4,153,358	0	4,153,358	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,318,626		1,318,626	0	1,318,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315,982		1,315,982	0	1,315,982	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	03630	ULTRA SOUND	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,058,183		1,058,183	0	1,058,183	60.00
66.00	06600	PHYSICAL THERAPY	680,674	0	680,674	0	680,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,011	0	304,011	0	304,011	67.00
68.00	06800	SPEECH PATHOLOGY	160,072	0	160,072	0	160,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,993		75,993	0	75,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,534		994,534	0	994,534	73.00
73.01	07301	ONCOLOGY DRUGS	213,568		213,568	0	213,568	73.01
76.00	03020	CARDIOPULMONARY	835,041		835,041	0	835,041	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	4,225,540		4,225,540	0	4,225,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,069,982		1,069,982		1,069,982	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	16,405,564	0	16,405,564	0	16,405,564	200.00
201.00		Less Observation Beds	1,069,982		1,069,982		1,069,982	201.00
202.00		Total (see instructions)	15,335,582	0	15,335,582	0	15,335,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,108,918		1,108,918			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,433	671,038	673,471	1.957955	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,355	4,144,773	4,293,128	0.306532	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	142,942	1,998,896	2,141,838	0.494054	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	182,237	825,194	1,007,431	0.675653	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,520	334,300	479,820	0.633594	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	64,650	70,772	135,422	1.182024	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,399	4,399	17.275063	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	449,176	1,046,015	1,495,191	0.665155	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	120,668	120,668	1.769881	0.000000	73.01
76.00	03020	CARDIOPULMONARY	97,012	889,844	986,856	0.846163	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	130,384	10,959,987	11,090,371	0.381010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,480	801,893	813,373	1.315487	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	2,483,107	21,867,779	24,350,886			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,483,107	21,867,779	24,350,886			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	03630	ULTRA SOUND	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03020	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,343	673,471	0.082176	2,433	200	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,911	4,293,128	0.022108	86,114	1,904	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	77,733	2,141,838	0.036293	82,145	2,981	60.00
66.00	06600	PHYSICAL THERAPY	46,451	1,007,431	0.046108	69,508	3,205	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,739	479,820	0.045307	48,352	2,191	67.00
68.00	06800	SPEECH PATHOLOGY	12,420	135,422	0.091713	54,900	5,035	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,438	4,399	0.554217	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,105	1,495,191	0.022810	290,236	6,620	73.00
73.01	07301	ONCOLOGY DRUGS	7,324	120,668	0.060695	0	0	73.01
76.00	03020	CARDIOPULMONARY	50,068	986,856	0.050735	58,899	2,988	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	137,362	11,090,371	0.012386	5,325	66	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	105,017	813,373	0.129113	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	644,911	23,241,968		697,912	25,190	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	673,471	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,293,128	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	03630	ULTRA SOUND	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,141,838	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,007,431	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	479,820	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	135,422	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,399	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,495,191	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	120,668	0.000000	73.01
76.00	03020	CARDIOPULMONARY	0	0	0	986,856	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,090,371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	813,373	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	23,241,968		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,433	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	86,114	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	82,145	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	69,508	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	48,352	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	54,900	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	290,236	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.000000	58,899	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	5,325	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		697,912	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | 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	1.957955	0	243,207	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.306532	0	1,032,769	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.494054	0	541,753	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.675653	0	318,306	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633594	0	111,043	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.182024	0	19,034	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17.275063	0	641	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.665155	0	316,287	277	0	73.00
73.01	07301	ONCOLOGY DRUGS	1.769881	0	25,411	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.846163	0	353,056	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.381010	0	2,688,786	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.315487	0	295,883	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	5,946,176	277	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	5,946,176	277	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	476,188	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,577	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	267,655	0		60.00
66.00	06600	PHYSICAL THERAPY	215,064	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	70,356	0		67.00
68.00	06800	SPEECH PATHOLOGY	22,499	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,073	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	210,380	184		73.00
73.01	07301	ONCOLOGY DRUGS	44,974	0		73.01
76.00	03020	CARDIOPULMONARY	298,743	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,024,454	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	389,230	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	3,347,193	184		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,347,193	184		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.957955	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.306532	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.494054	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.675653	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633594	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.182024	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17.275063	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.665155	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	1.769881	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.846163	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.381010	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.315487	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	0	0		73.01
76.00	03020	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:13 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	1.957955	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.306532	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.494054	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.675653	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633594	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.182024	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17.275063	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.665155	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	1.769881	0	0	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.846163	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.381010	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.315487	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 12:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	03630	ULTRA SOUND	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY DRUGS	0	0		73.01
76.00	03020	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	884	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	739	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)	517	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	122	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	23	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)	387	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)	122	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,153,358	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)	3,565	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)	591,573	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,561,785	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,561,785	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)	4,819.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,865,239	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,865,239	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	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)	459,156	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,324,395	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)	588,008	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)	588,008	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)	222	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	4,819.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,069,982	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	407,645	4,153,358	0.098148	1,069,982	105,017	90.00
91.00	Nursing School cost	0	4,153,358	0.000000	1,069,982	0	91.00
92.00	Allied health cost	0	4,153,358	0.000000	1,069,982	0	92.00
93.00	All other Medical Education	0	4,153,358	0.000000	1,069,982	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:13 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)	884	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	739	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)	517	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	122	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	23	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)	5	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,153,358	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)	3,565	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)	591,573	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,561,785	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,561,785	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)	4,819.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	24,099	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)	24,099	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:13 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)	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)	12,360	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	36,459	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)	222	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	4,819.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,069,982	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 12:13 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	407,645	4,153,358	0.098148	1,069,982	105,017	90.00
91.00	Nursing School cost	0	4,153,358	0.000000	1,069,982	0	91.00
92.00	Allied health cost	0	4,153,358	0.000000	1,069,982	0	92.00
93.00	All other Medical Education	0	4,153,358	0.000000	1,069,982	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		678,305		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.957955	2,433	4,764	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.306532	86,114	26,397	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.494054	82,145	40,584	60.00
66.00	06600	PHYSICAL THERAPY	0.675653	69,508	46,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633594	48,352	30,636	67.00
68.00	06800	SPEECH PATHOLOGY	1.182024	54,900	64,893	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17.275063	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.665155	290,236	193,052	73.00
73.01	07301	ONCOLOGY DRUGS	1.769881	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.846163	58,899	49,838	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.381010	5,325	2,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.315487	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		697,912	459,156	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)		697,912		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.957955	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.306532	4,896	1,501	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.494054	9,467	4,677	60.00
66.00	06600	PHYSICAL THERAPY	0.675653	81,822	55,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633594	71,913	45,564	67.00
68.00	06800	SPEECH PATHOLOGY	1.182024	2,253	2,663	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17.275063	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.665155	23,080	15,352	73.00
73.01	07301	ONCOLOGY DRUGS	1.769881	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.846163	2,654	2,246	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.381010	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.315487	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		196,085	127,286	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)		196,085		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 12:13 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		9,100		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.957955	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.306532	6,060	1,858	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	03630	ULTRA SOUND	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.494054	2,270	1,122	60.00
66.00	06600	PHYSICAL THERAPY	0.675653	1,066	720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.633594	611	387	67.00
68.00	06800	SPEECH PATHOLOGY	1.182024	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17.275063	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.665155	6,713	4,465	73.00
73.01	07301	ONCOLOGY DRUGS	1.769881	0	0	73.01
76.00	03020	CARDIOPULMONARY	0.846163	219	185	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.381010	9,510	3,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.315487	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,449	12,360	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)		26,449		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 12:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,347,377	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,347,377	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,380,851	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	2,238	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,077,529	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,301,084	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,301,084	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,301,084	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)	54,018	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	35,112	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	54,018	36.00
37.00	Subtotal (see instructions)	2,336,196	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,336,196	40.00
40.01	Sequestration adjustment (see instructions)	46,724	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	441,124	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,848,348	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	35,542	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: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		709,641		441,124	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		709,641		441,124	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		1,463,331		1,848,348	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,172,972		2,289,472	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: 15-1316 | Component CCN: 15-Z316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		242,232		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		242,232		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		465,766		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		707,998		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 12:13 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/29/2018 12:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	593,888	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	128,559	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	122	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	722,447	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	722,447	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	722,447	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	722,447	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	722,447	0	19.00
19.01	Sequestration adjustment (see instructions)	14,449	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	242,232	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	465,766	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	7,598	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 12:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,324,395	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,324,395	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,347,639	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,347,639	19.00
20.00	Deductibles (exclude professional component)	130,284	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,217,355	22.00
23.00	Coinsurance	987	23.00
24.00	Subtotal (line 22 minus line 23)	2,216,368	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,461	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	950	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,461	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,217,318	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,217,318	30.00
30.01	Sequestration adjustment (see instructions)	44,346	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	709,641	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	1,463,331	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	24,689	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 12:13 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	-781,014	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,174,072	0	0	0	4.00
5.00	Other receivable	-5,299,088	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	287,688	0	0	0	7.00
8.00	Prepaid expenses	69,373	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-3,548,969	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,423,608	0	0	0	23.00
24.00	Accumulated depreciation	-475,739	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,947,869	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	833,437	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	833,437	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,232,337	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,391,331	0	0	0	37.00
38.00	Salaries, wages, and fees payable	490,167	0	0	0	38.00
39.00	Payroll taxes payable	25,211	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	-817,371	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,089,338	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)	8,089,338	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-6,857,001				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)	-6,857,001	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,232,337	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 12:13 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		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,857,000				2.00
3.00	Total (sum of line 1 and line 2)		-6,857,000		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-6,857,000		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-6,857,001		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		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: 15-1316 | Period: From 06/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2018 12:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,108,918		1,108,918	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,108,918		1,108,918	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,108,918		1,108,918	17.00
18.00	Ancillary services	1,232,325	10,105,899	11,338,224	18.00
19.00	Outpatient services	141,864	11,761,880	11,903,744	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,483,107	21,867,779	24,350,886	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,949,743		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,949,743		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/29/2018 12:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	24,350,886	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,400,801	2.00
3.00	Net patient revenues (line 1 minus line 2)	6,950,085	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,949,743	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,999,658	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	142,658	24.00
25.00	Total other income (sum of lines 6-24)	142,658	25.00
26.00	Total (line 5 plus line 25)	-6,857,000	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)	-6,857,000	29.00