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: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 9:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2017 Time: 9:24 am
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 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 MARION GENERAL HOSPITAL (15-0011) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	-779,542	-36,970	1,417	-51,935	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-4,841	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-784,383	-36,970	1,417	-51,935	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: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:19 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 441 WABASH AVENUE	PO Box:			1.00
2.00	City: MARION	State: IN	Zip Code: 46952-	County: GRANT	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	MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	MARION GENERAL HOSPITAL REHAB	15T011	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	478	1,873	0	0	2,527	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.	11	19	0	0	88		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:19 am

		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.	1		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.	07/01/2016	06/30/2017	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:19 am

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

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

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

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,109,265	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.	Y	Y	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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2017 9:19 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:19 am

		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)	07/01/2015	09/30/2015	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2017 9:19 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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	10/09/2017	Y	10/09/2017	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: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 9:19 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 9:19 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2017 9:19 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	80	29,200	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	19	6,935	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)		99	36,135	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		117				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2017 9:19 am

	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)	7,503	478	14,540			1.00
2.00	HMO and other (see instructions)	2,451	4,400				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	136	107				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,503	478	14,540			7.00
8.00	INTENSIVE CARE UNIT	1,643	0	4,075			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	1,850			13.00
14.00	Total (see instructions)	9,146	478	20,465	0.00	722.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	1,951	11	2,433	0.00	16.04	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	738.70	27.00
28.00	Observation Bed Days		859	2,761			28.00
29.00	Ambulance Trips	1,453					29.00
30.00	Employee discount days (see instruction)			149			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2017 9:19 am

	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	2,127	80	4,932	1.00
2.00	HMO and other (see instructions)			517	1,093		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				9		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	2,127	80	4,932	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	191	1	237	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II | Date/Time Prepared: 11/28/2017 9:19 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	47,623,435	-31,835	47,591,600	1,890,033.00	25.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		90,563	0	90,563	510.95	177.24	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		8,617,252	262,666	8,879,918	460,739.00	19.27	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,046,210	0	1,046,210	14,885.00	70.29	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		254,775	0	254,775	1,698.50	150.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,297,187	0	15,297,187			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		4,221,103	0	4,221,103			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		5,278	0	5,278			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II | Date/Time Prepared: 11/28/2017 9:19 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,050,584	24,165	1,074,749	32,802.00	32.76	26.00
27.00	Administrative & General	5.00	8,697,185	-188,911	8,508,274	349,035.00	24.38	27.00
28.00	Administrative & General under contract (see inst.)		1,900,930	0	1,900,930	12,299.59	154.55	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	684,988	-34,124	650,864	34,066.00	19.11	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,525,919	0	1,525,919	106,060.00	14.39	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		343,360	0	343,360	18,214.00	18.85	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,300,037	-447,118	852,919	19,364.00	44.05	38.00
39.00	Central Services and Supply	14.00	124,240	14,826	139,066	8,061.00	17.25	39.00
40.00	Pharmacy	15.00	2,449,247	-1,069	2,448,178	60,589.00	40.41	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2017 9:19 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		51,393,644	-31,835	51,361,809	2,026,606.59	25.34	1.00
2.00	Excluded area salaries (see instructions)		8,617,252	262,666	8,879,918	460,739.00	19.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)		42,776,392	-294,501	42,481,891	1,565,867.59	27.13	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,300,985	0	1,300,985	16,583.50	78.45	4.00
5.00	Subtotal wage-related costs (see inst.)		15,302,465	0	15,302,465	0.00	36.02	5.00
6.00	Total (sum of lines 3 thru 5)		59,379,842	-294,501	59,085,341	1,582,451.09	37.34	6.00
7.00	Total overhead cost (see instructions)		18,076,490	-632,231	17,444,259	640,490.59	27.24	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 11/28/2017 9:19 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,191,744	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	3,493,877	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	159,015	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	9,461,981	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	30,830	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	333,343	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	346,308	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,140,781	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	16,961	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	348,728	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,523,568	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	67,080	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part V | Date/Time Prepared: 11/28/2017 9:19 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,046,210	19,523,568	1.00
2.00	Hospital	1,046,210	19,523,568	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/28/2017 9:19 am

		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)	0.275561	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,542,060	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	72,580,224	6.00
7.00	Medicaid cost (line 1 times line 6)	20,000,279	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)	5,458,219	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)	5,458,219	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)	9,595,488	2,575,361	12,170,849	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,644,142	2,575,361	5,219,503	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,835	26,021	28,856	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,641,307	2,549,340	5,190,647	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	13,711,520	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	684,829	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,053,583	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	12,657,937	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,856,788	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,047,435	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,505,654	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		13,178,466	13,178,466	-1,118,579	12,059,887	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,050,584	19,377,607	20,428,191	60,954	20,489,145	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,697,185	23,719,578	32,416,763	-57,199	32,359,564	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	0	0	1,450,288	1,450,288	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	684,988	4,303,756	4,988,744	410,384	5,399,128	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	451,606	451,606	8.00
9.00	00900	HOUSEKEEPING	0	3,014,335	3,014,335	-442,364	2,571,971	9.00
10.00	01000	DIETARY	0	2,023,058	2,023,058	-1,490,075	532,983	10.00
13.00	01300	NURSING ADMINISTRATION	1,300,037	96,758	1,396,795	-447,118	949,677	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	124,240	259,882	384,122	14,826	398,948	14.00
15.00	01500	PHARMACY	2,449,247	8,389,651	10,838,898	-7,846,928	2,991,970	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,387,965	924,494	8,312,459	-758,388	7,554,071	30.00
31.00	03100	INTENSIVE CARE UNIT	2,277,576	389,618	2,667,194	0	2,667,194	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	905,393	795,132	1,700,525	0	1,700,525	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	992,734	992,734	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,608,635	13,608,635	174,348	13,782,983	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,147,369	3,073,945	6,221,314	-1,094,691	5,126,623	54.00
57.00	05700	CT SCAN	0	0	0	1,032,456	1,032,456	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	521,698	521,698	58.00
59.00	05900	CARDIAC CATHETERIZATION	575,696	1,203,437	1,779,133	42,969	1,822,102	59.00
60.00	06000	LABORATORY	2,359,056	4,990,852	7,349,908	-19,092	7,330,816	60.00
60.01	06001	ONCOLOGY	987,181	595,967	1,583,148	0	1,583,148	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	1,293,566	731,009	2,024,575	31,895	2,056,470	65.00
66.00	06600	PHYSICAL THERAPY	1,550,436	496,972	2,047,408	0	2,047,408	66.00
69.00	06900	ELECTROCARDIOLOGY	745,291	132,905	878,196	106,763	984,959	69.00
69.01	06901	CARDIAC REHAB	118,777	5,053	123,830	43,522	167,352	69.01
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	7,846,928	7,846,928	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	260,712	150,879	411,591	32,507	444,098	90.00
91.00	09100	EMERGENCY	3,996,277	1,095,466	5,091,743	-57,711	5,034,032	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						
95.00	09500	AMBULANCE SERVICES	1,108,899	151,156	1,260,055	57,711	1,317,766	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,020,475	102,708,611	143,729,086	-60,556	143,668,530	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,507	18,507	25,464	43,971	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	83,093	11,834	94,927	10,785	105,712	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	1,117,843	1,117,843	-1,022,923	94,920	192.05
192.06	19206	UROLOGY	282,582	824,877	1,107,459	45,980	1,153,439	192.06
192.08	19211	PARISH NURSING	22,797	12,264	35,061	14,935	49,996	192.08
192.09	19212	BIOTERRORISM GRANT	0	5,881	5,881	34,125	40,006	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	128,448	470,852	599,300	28,823	628,123	192.12
192.14	19210	MGH PHYS PRACT MGMT	1,028,983	592,791	1,621,774	46,405	1,668,179	192.14
192.15	19215	MGH MARION SURGEONS	528,336	2,133,354	2,661,690	75,290	2,736,980	192.15
192.16	19216	MGH MGH MED ONC	2,603	1,352,726	1,355,329	0	1,355,329	192.16
192.17	19217	MGH FMC SOUTH	815,098	2,277,114	3,092,212	345,344	3,437,556	192.17
192.18	19218	MGH FAIRM MED ASSOC	33,936	134,112	168,048	307	168,355	192.18
192.19	19219	MGH FMC MARION	248,111	526,638	774,749	39,063	813,812	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	335,863	767,501	1,103,364	1,239	1,104,603	193.01
193.02	19302	MGH FMC GAS CITY	206,246	533,716	739,962	81,641	821,603	193.02
193.03	19303	MGH HOSPITALISTS	0	3,616,836	3,616,836	0	3,616,836	193.03
193.04	19304	MGH MAR FAM PRACT	945,845	2,035,526	2,981,371	0	2,981,371	193.04
193.05	19305	MGH FMC SWAYZEE	79,114	160,573	239,687	25,553	265,240	193.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/28/2017 9:19 am

		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	
193.06	19306	MGH PEDIATRIC CTR	249,777	976,178	1,225,955	60,693	1,286,648	193.06
193.07	19307	MGH SPECIALTY PHYS	85,283	248,955	334,238	14,603	348,841	193.07
193.08	19308	MGH FMC CONVERSE	122,724	214,503	337,227	307	337,534	193.08
193.09	19309	MGH UPLAND HEALTH	440,036	1,128,214	1,568,250	6,933	1,575,183	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	553,931	2,061,964	2,615,895	0	2,615,895	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	250,477	250,477	194.03
194.04	07953	MGH WORK SOLUTIONS	354,812	487,784	842,596	47,864	890,460	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	55,342	97,991	153,333	0	153,333	194.05
194.08	07957	MGH SMMP BLDG	0	308,531	308,531	-72,352	236,179	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,001	6,001	0	6,001	194.10
194.11	07960	FAIRMOUNT	0	27,706	27,706	0	27,706	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	17,541	17,541	0	17,541	194.14
200.00		TOTAL (SUM OF LINES 118-199)	47,623,435	124,876,924	172,500,359	0	172,500,359	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-33,430	12,026,457		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,105,066	17,384,079		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,020,910	20,338,654		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
6.01	00601	CAFETERIA	-19,766	1,430,522		6.01
6.02	00602	CAFETERIA	0	0		6.02
7.00	00700	OPERATION OF PLANT	-161,266	5,237,862		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,877	448,729		8.00
9.00	00900	HOUSEKEEPING	-2,761	2,569,210		9.00
10.00	01000	DIETARY	-6,116	526,867		10.00
13.00	01300	NURSING ADMINISTRATION	-21	949,656		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-491	398,457		14.00
15.00	01500	PHARMACY	-36,318	2,955,652		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-27,512	7,526,559		30.00
31.00	03100	INTENSIVE CARE UNIT	-465	2,666,729		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	-71,297	1,629,228		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	992,734		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-436,036	13,346,947		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-167,508	4,959,115		54.00
57.00	05700	CT SCAN	0	1,032,456		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	521,698		58.00
59.00	05900	CARDIAC CATHETERIZATION	-5,064	1,817,038		59.00
60.00	06000	LABORATORY	-83,086	7,247,730		60.00
60.01	06001	ONCOLOGY	-6,668	1,576,480		60.01
60.02	06002	RADIATION ONCOLOGY	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	-2,517	2,053,953		65.00
66.00	06600	PHYSICAL THERAPY	-108	2,047,300		66.00
69.00	06900	ELECTROCARDIOLOGY	-53,789	931,170		69.00
69.01	06901	CARDIAC REHAB	-9	167,343		69.01
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	7,846,928		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-317	443,781		90.00
91.00	09100	EMERGENCY	-166,303	4,867,729		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				
95.00	09500	AMBULANCE SERVICES	-61,688	1,256,078		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-16,471,389	127,197,141		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,971		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	VISITOR MEALS	0	0		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	105,712		192.03
192.04	19204	LIFELINE	0	0		192.04
192.05	19205	OWNED PROPERTIES	0	94,920		192.05
192.06	19206	UROLOGY	-42,656	1,110,783		192.06
192.08	19211	PARISH NURSING	0	49,996		192.08
192.09	19212	BIOTERRORISM GRANT	0	40,006		192.09
192.10	19214	BREAST PUMPS	0	0		192.10
192.12	19209	LUNG CENTER	-46,391	581,732		192.12
192.14	19210	MGH PHYS PRACT MGMT	-65,348	1,602,831		192.14
192.15	19215	MGH MARION SURGEONS	-108,462	2,628,518		192.15
192.16	19216	MGH MGH MED ONC	0	1,355,329		192.16
192.17	19217	MGH FMC SOUTH	-323,185	3,114,371		192.17
192.18	19218	MGH FAIRM MED ASSOC	-26,054	142,301		192.18
192.19	19219	MGH FMC MARION	-48,785	765,027		192.19
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	0	1,104,603		193.01
193.02	19302	MGH FMC GAS CITY	-139,146	682,457		193.02
193.03	19303	MGH HOSPITALISTS	0	3,616,836		193.03
193.04	19304	MGH MAR FAM PRACT	0	2,981,371		193.04
193.05	19305	MGH FMC SWAYZEE	-29,141	236,099		193.05
193.06	19306	MGH PEDIATRIC CTR	-63,607	1,223,041		193.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
193.07	19307	MGH SPECIALTY PHYS	-28,632	320,209		193.07
193.08	19308	MGH FMC CONVERSE	0	337,534		193.08
193.09	19309	MGH UPLAND HEALTH	0	1,575,183		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0		193.11
193.12	19312	OB/GYN	0	2,615,895		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0		193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07950	MOW	0	0		194.01
194.02	07951	MENTAL HEALTH	0	0		194.02
194.03	07952	ADVERTISING	0	250,477		194.03
194.04	07953	MGH WORK SOLUTIONS	-104,758	785,702		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	153,333		194.05
194.08	07957	MGH SMMP BLDG	0	236,179		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,001		194.10
194.11	07960	FAIRMOUNT	0	27,706		194.11
194.12	07961	GAS CITY	0	0		194.12
194.13	07962	LYONS	0	0		194.13
194.14	07964	WABASH	0	17,541		194.14
200.00		TOTAL (SUM OF LINES 118-199)	-17,497,554	155,002,805		200.00

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/28/2017 9:19 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SATELLITE OFFICE RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	13,768	4,908	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	73,080	7,926	2.00
	0		86,848	12,834	
	B - CAFETERIA RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	68,652	1.00
2.00	CAFETERIA	6.01	0	1,450,288	2.00
	0		0	1,518,940	
	C - ADMIN DIRECTOR RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	24,165	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	14,826	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	234,346	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	42,969	0	4.00
5.00	RESPIRATORY THERAPY	65.00	31,895	0	5.00
6.00	ELECTROCARDIOLOGY	69.00	71,615	0	6.00
7.00	CARDIAC REHAB	69.01	28,646	0	7.00
8.00	AMBULANCE SERVICES	95.00	57,711	0	8.00
9.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	25,464	0	9.00
10.00	GREAT BEGINNINGS/MATERNAL	192.03	10,785	0	10.00
11.00	PARISH NURSING	192.08	11,009	0	11.00
12.00	BIOTERRORISM GRANT	192.09	34,125	0	12.00
	0		587,556	0	
	D - ADVERTISING				
1.00	ADVERTISING	194.03	158,372	92,105	1.00
	0		158,372	92,105	
	E - LEASED PROPERTY				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36,789	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	122,539	2.00
3.00	OPERATION OF PLANT	7.00	0	442,868	3.00
4.00	HOUSEKEEPING	9.00	0	8,881	4.00
5.00	DIETARY	10.00	0	28,258	5.00
6.00	OPERATING ROOM	50.00	0	174,348	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	306,408	7.00
8.00	CT SCAN	57.00	0	21,727	8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	24,502	9.00
10.00	LABORATORY	60.00	0	77,763	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	16,472	11.00
12.00	CARDIAC REHAB	69.01	0	14,876	12.00
13.00	CLINIC	90.00	0	32,507	13.00
14.00	PARISH NURSING	192.08	0	3,926	14.00
15.00	LUNG CENTER	192.12	0	28,823	15.00
16.00	MGH PHYS PRACT MGMT	192.14	0	46,405	16.00
17.00	MGH MARION SURGEONS	192.15	0	75,290	17.00
18.00	MGH FMC SOUTH	192.17	0	354,937	18.00
19.00	MGH FAIRM MED ASSOC	192.18	0	307	19.00
20.00	MGH FMC MARION	192.19	0	39,063	20.00
21.00	UROLOGY	192.06	0	45,980	21.00
22.00	MGH WORK SOLUTIONS	194.04	0	47,864	22.00
23.00	MGH FMC NORTHWOOD	193.01	0	1,239	23.00
24.00	MGH FMC GAS CITY	193.02	0	81,641	24.00
25.00	MGH FMC SWAYZEE	193.05	0	25,553	25.00
26.00	MGH PEDIATRIC CTR	193.06	0	60,693	26.00
27.00	MGH SPECIALTY PHYS	193.07	0	14,603	27.00
28.00	MGH FMC CONVERSE	193.08	0	307	28.00
29.00	MGH UPLAND HEALTH	193.09	0	6,933	29.00
	0		0	2,141,502	
	F - PHARMACY RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,846,928	1.00
	0		0	7,846,928	
	G - CT/MRI RECLASS				
1.00	CT SCAN	57.00	510,534	498,625	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	250,638	244,791	2.00
	0		761,172	743,416	
	H - SHORT TERM DISABILITY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,736	1.00
2.00	PHARMACY	15.00	0	1,069	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	6,324	3.00
4.00	EMERGENCY	91.00	0	7,706	4.00
	0		0	31,835	

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/28/2017 9:19 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	I - NURSERY RECLASS				
1.00	NURSERY	43.00	860,988	131,746	1.00
	0		860,988	131,746	
	J - SMMP HOUSEKEEPING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,890	1.00
2.00	OPERATION OF PLANT	7.00	0	1,640	2.00
3.00	HOUSEKEEPING	9.00	0	361	3.00
4.00	DIETARY	10.00	0	607	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,483	5.00
6.00	CT SCAN	57.00	0	1,570	6.00
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,767	7.00
8.00	LABORATORY	60.00	0	2,827	8.00
9.00	MGH FMC SOUTH	192.17	0	25,207	9.00
	0		0	72,352	
	K - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	451,606	1.00
	0		0	451,606	
	L - PHYSICIAN MEDICAL DIRECTOR RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	34,800	0	1.00
	TOTALS		34,800	0	
500.00	Grand Total: Increases		2,489,736	13,043,264	500.00

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/28/2017 9:19 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SATELLITE OFFICE RECLASS						
1.00	LABORATORY	60.00	13,768	4,908	0		1.00
2.00	LABORATORY	60.00	73,080	7,926	0		2.00
	0		86,848	12,834			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	68,652	0		1.00
2.00	DIETARY	10.00	0	1,450,288	0		2.00
	0		0	1,518,940			
	C - ADMIN DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	48,603	0	0		1.00
2.00	OPERATION OF PLANT	7.00	34,124	0	0		2.00
3.00	NURSING ADMINISTRATION	13.00	447,118	0	0		3.00
4.00	EMERGENCY	91.00	57,711	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	0		587,556	0			
	D - ADVERTISING						
1.00	ADMINISTRATIVE & GENERAL	5.00	158,372	92,105	0		1.00
	0		158,372	92,105			
	E - LEASED PROPERTY						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,118,579	10		1.00
2.00	OWNED PROPERTIES	192.05	0	1,022,923	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
	0		0	2,141,502			
	F - PHARMACY RECLASS						
1.00	PHARMACY	15.00	0	7,846,928	0		1.00
	0		0	7,846,928			
	G - CT/MRI RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	761,172	743,416	0		1.00
2.00		0.00	0	0	0		2.00
	0		761,172	743,416			
	H - SHORT TERM DISABILITY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	16,736	0	0		1.00
2.00	PHARMACY	15.00	1,069	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	6,324	0	0		3.00
4.00	EMERGENCY	91.00	7,706	0	0		4.00
	0		31,835	0			
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	860,988	131,746	0		1.00
	0		860,988	131,746			

RECLASSIFICATIONS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/28/2017 9:19 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - SMMP HOUSEKEEPING RECLASS						
1.00	MGH SMMP BLDG	194.08	0	72,352	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		0	72,352			
	K - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	451,606	0		1.00
	0		0	451,606			
	L - PHYSICIAN MEDICAL DIRECTOR RECLASS						
1.00	MGH FMC SOUTH	192.17	34,800	0	0		1.00
	TOTALS		34,800	0			
500.00	Grand Total: Decreases		2,521,571	13,011,429			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2017 9:19 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,646,549	0	0	0	0	1.00
2.00	Land Improvements	3,353,531	0	0	0	0	2.00
3.00	Buildings and Fixtures	113,907,382	8,862,626	0	8,862,626	401,135	3.00
4.00	Building Improvements	2,473,672	813,709	0	813,709	0	4.00
5.00	Fixed Equipment	1,005,608	315,275	0	315,275	176,139	5.00
6.00	Movable Equipment	87,358,553	6,516,339	0	6,516,339	14,212,887	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	212,745,295	16,507,949	0	16,507,949	14,790,161	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	212,745,295	16,507,949	0	16,507,949	14,790,161	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,646,549	0	1.00
2.00	Land Improvements	3,353,531	0	2.00
3.00	Buildings and Fixtures	122,368,873	0	3.00
4.00	Building Improvements	3,287,381	0	4.00
5.00	Fixed Equipment	1,144,744	0	5.00
6.00	Movable Equipment	79,662,005	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,463,083	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	214,463,083	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2017 9:19 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,178,466	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	13,178,466	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13,178,466		1.00
3.00	Total (sum of lines 1-2)	0	13,178,466		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2017 9:19 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	214,463,083	0	214,463,083	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	214,463,083	0	214,463,083	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	13,178,466	-1,118,579	1.00
3.00	Total (sum of lines 1-2)	0	0	0	13,178,466	-1,118,579	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-33,430	0	0	0	12,026,457	1.00
3.00	Total (sum of lines 1-2)	-33,430	0	0	0	12,026,457	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/28/2017 9:19 am

	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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	-808,741			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-15,992	CAFETERIA	6.01	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
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
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/28/2017 9:19 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RETURNED CHECK FEE	B	-400	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYSICIAN PRIV APPLICATION	B	-2,450	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-51,213	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CHILD SEAT SAFETY INSPECTION	B	-1,930	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HEALTH SCREENING FEES - LAB	B	-16,350	LABORATORY	60.00	0	33.04
33.05	HEALTH SCREENING FEES - RAD	B	-8,093	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MED STAFF OTHER SCREENING-MED STAFF	B	1,384	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HEALTH SCREENING FEES	B	-1,721	LABORATORY	60.00	0	33.07
33.08	FLU SHOT HEALTH SCREENS	B	-10	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	REBATE	B	-52,271	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	RENT SPACE UPLAND	B	-25,692	LABORATORY	60.00	0	33.11
33.12	PAGER RENTAL	B	-1,900	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	SALE OF SCRAP, WASTE, ETC,	B	-6,579	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.16	PCC MARKETING AG	B	-1,219	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	EDUCATIONAL WORKSHOP	B	-1,788	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OPT HEALTH LINEN SEV	B	-2,877	LAUNDRY & LINEN SERVICE	8.00	0	33.18
33.19	AMBULANCE SVC - ASSISTS	B	-55,250	AMBULANCE SERVICES	95.00	0	33.19
33.20	AMBULANCE SVC - CORONER SVC	B	-248	AMBULANCE SERVICES	95.00	0	33.20
33.21	AMBULANCE SVC - LINEN SERVICES	B	-4,608	AMBULANCE SERVICES	95.00	0	33.21
33.22	AMBULANCE SVC - COMMUNITY EVENT STAF	B	-1,391	AMBULANCE SERVICES	95.00	0	33.22
33.23	CONTRACT ARU OTH ARU MEDICAL DIRECTO	B	-59,512	SUBPROVIDER - IRF	41.00	0	33.23
33.24	SCHOOL PHYS OTH SCHOOL PHYS	B	-6,720	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	PHLEBOTOMY	B	-5,970	LABORATORY	60.00	0	33.25
33.27	CLINICAL STUDY- OTHER	B	-5,252	ONCOLOGY	60.01	0	33.27
33.28	SICK CHILD CARE PROGRAM	B	-1,285	ADULTS & PEDIATRICS	30.00	0	33.28
33.30	UNCLAIMED OTHER 125 MED/CHILD CARE E	B	-19,586	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	UNCLAIMED OTHER MONIES RECOVERED	B	-3,748	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	VENDING MACHINES	B	-3,774	CAFETERIA	6.01	0	33.32
33.33	CPR TRAIN OTH AHA COMMUNITY	B	-7,961	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PHYSICIAN RECRUITMENT	A	-936,037	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	ED ANESTHESIOLOGIST	A	-1,380,983	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	GAIN ON DISPOSAL	A	-692,138	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	TELEVISION AND RADIO SERVICE	A	-49,147	OPERATION OF PLANT	7.00	0	33.37
33.39	TELEPHONE SERVICE	A	-111,175	OPERATION OF PLANT	7.00	0	33.39
33.40	MISC REV	B	-116	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	MISC REV	B	-390	ONCOLOGY	60.01	0	33.41
33.42	ENTERTAINMENT EXP	A	-152	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	EMPLOYEE USE OF AUTO	A	-3,831	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	DONATIONS	A	-230,217	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	VHA OPPORTUNITY	A	-124	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	VHA OPPORTUNITY	A	-11,857	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	VHA OPPORTUNITY	A	-944	OPERATION OF PLANT	7.00	0	33.47
33.48	VHA OPPORTUNITY	A	-2,761	HOUSEKEEPING	9.00	0	33.48
33.49	VHA OPPORTUNITY	A	-6,116	DIETARY	10.00	0	33.49
33.50	VHA OPPORTUNITY	A	-491	CENTRAL SERVICES & SUPPLY	14.00	0	33.50
33.51	VHA OPPORTUNITY	A	-36,166	PHARMACY	15.00	0	33.51
33.52	VHA OPPORTUNITY	A	-26,227	ADULTS & PEDIATRICS	30.00	0	33.52
33.53	VHA OPPORTUNITY	A	-465	INTENSIVE CARE UNIT	31.00	0	33.53
33.54	VHA OPPORTUNITY	A	-110	SUBPROVIDER - IRF	41.00	0	33.54
33.55	VHA OPPORTUNITY	A	-19,325	OPERATING ROOM	50.00	0	33.55
33.56	VHA OPPORTUNITY	A	-9,415	RADIOLOGY-DIAGNOSTIC	54.00	0	33.56
33.57	VHA OPPORTUNITY	A	-5,064	CARDIAC CATHETERIZATION	59.00	0	33.57
33.58	VHA OPPORTUNITY	A	-21,653	LABORATORY	60.00	0	33.58

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/28/2017 9:19 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.59	VHA OPPORTUNITY	A	-394	ONCOLOGY	60.01	0	33.59
33.60	VHA OPPORTUNITY	A	-2,517	RESPIRATORY THERAPY	65.00	0	33.60
33.61	VHA OPPORTUNITY	A	-108	PHYSICAL THERAPY	66.00	0	33.61
33.62	VHA OPPORTUNITY	A	-134	ELECTROCARDIOLOGY	69.00	0	33.62
33.63	VHA OPPORTUNITY	A	-9	CARDIAC REHAB	69.01	0	33.63
33.64	VHA OPPORTUNITY	A	-317	CLINIC	90.00	0	33.64
33.65	VHA OPPORTUNITY	A	-1,303	EMERGENCY	91.00	0	33.65
33.66	VHA OPPORTUNITY	A	-191	AMBULANCE SERVICES	95.00	0	33.66
33.67	FINANCE BANK SERVICE CHARGES	A	-133,172	ADMINISTRATIVE & GENERAL	5.00	0	33.67
33.68	FINANCE DISCOUNT PAYMENTS	A	7,756	ADMINISTRATIVE & GENERAL	5.00	0	33.68
33.71	ELIMINATING ENTRIES	A	-65,348	MGH PHYS PRACT MGMT	192.14	0	33.71
33.72	ELIMINATING ENTRIES	A	-104,758	MGH WORK SOLUTIONS	194.04	0	33.72
33.73	ELIMINATING ENTRIES	A	-46,391	LUNG CENTER	192.12	0	33.73
33.74	ELIMINATING ENTRIES	A	-108,462	MGH MARION SURGEONS	192.15	0	33.74
33.75	ELIMINATING ENTRIES	A	-323,185	MGH FMC SOUTH	192.17	0	33.75
33.76	ELIMINATING ENTRIES	A	-26,054	MGH FAIRM MED ASSOC	192.18	0	33.76
33.77	ELIMINATING ENTRIES	A	-48,785	MGH FMC MARION	192.19	0	33.77
33.78	ELIMINATING ENTRIES	A	-139,146	MGH FMC GAS CITY	193.02	0	33.78
33.79	ELIMINATING ENTRIES	A	-29,141	MGH FMC SWAYZEE	193.05	0	33.79
33.80	ELIMINATING ENTRIES	A	-63,607	MGH PEDIATRIC CTR	193.06	0	33.80
33.81	ELIMINATING ENTRIES	A	-42,656	UROLOGY	192.06	0	33.81
33.82	ELIMINATING ENTRIES	A	-28,632	MGH SPECIALTY PHYS	193.07	0	33.82
33.83	LOBBYING COSTS	A	-18,391	ADMINISTRATIVE & GENERAL	5.00	0	33.83
33.84	LOBBYING COSTS	A	-21	NURSING ADMINISTRATION	13.00	0	33.84
33.85	LOBBYING COSTS	A	-152	PHARMACY	15.00	0	33.85
33.86	LOBBYING COSTS	A	-632	ONCOLOGY	60.01	0	33.86
33.87	OPERATING INTEREST INCOME	B	-33,430	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.87
33.88	ED ON CALL SVC A/C 7000.2512	A	-2,270,204	ADMINISTRATIVE & GENERAL	5.00	0	33.88
33.89	XIX ASSESSMENT FEE A/C 7200.7892	A	-6,193,977	ADMINISTRATIVE & GENERAL	5.00	0	33.89
33.90	SELF INSURANCE EXPENSE	A	-3,104,942	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.90
33.91			0		0.00	0	33.91
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,497,554				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2017 9:19 am

	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	41.00	SUBPROVIDER - IRF	11,675	11,675	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,655	53,655	0	0	0	2.00
3.00	50.00	OPERATING ROOM	416,711	416,711	0	0	0	3.00
4.00	91.00	EMERGENCY	165,000	165,000	0	0	0	4.00
5.00	60.00	LABORATORY	11,700	11,700	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	150,000	150,000	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			808,741	808,741	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	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	41.00	SUBPROVIDER - IRF	0	0	0	11,675		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,655		2.00
3.00	50.00	OPERATING ROOM	0	0	0	416,711		3.00
4.00	91.00	EMERGENCY	0	0	0	165,000		4.00
5.00	60.00	LABORATORY	0	0	0	11,700		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	150,000		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	808,741		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	12,026,457	12,026,457				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,384,079	459,787	17,843,866			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,338,654	2,004,080	3,263,774	25,606,508	25,606,508	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	1,430,522	160,246	0	1,590,768	314,800	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	5,237,862	3,083,996	249,671	8,571,529	1,696,237	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	448,729	69,714	0	518,443	102,596	8.00
9.00	00900	HOUSEKEEPING	2,569,210	107,556	0	2,676,766	529,711	9.00
10.00	01000	DIETARY	526,867	220,788	0	747,655	147,955	10.00
13.00	01300	NURSING ADMINISTRATION	949,656	22,963	327,180	1,299,799	257,220	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	398,457	78,622	53,346	530,425	104,967	14.00
15.00	01500	PHARMACY	2,955,652	101,288	939,121	3,996,061	790,789	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,526,559	1,425,353	2,591,218	11,543,130	2,284,293	30.00
31.00	03100	INTENSIVE CARE UNIT	2,666,729	330,588	873,678	3,870,995	766,039	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,629,228	316,236	347,309	2,292,773	453,721	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	992,734	0	330,275	1,323,009	261,813	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,346,947	1,140,857	0	14,487,804	2,867,039	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,959,115	682,488	943,379	6,584,982	1,303,115	54.00
57.00	05700	CT SCAN	1,032,456	49,654	195,841	1,277,951	252,896	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	521,698	58,859	96,145	676,702	133,914	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,817,038	166,284	237,320	2,220,642	439,447	59.00
60.00	06000	LABORATORY	7,247,730	421,747	871,619	8,541,096	1,690,215	60.00
60.01	06001	ONCOLOGY	1,576,480	0	378,683	1,955,163	386,911	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	2,053,953	151,602	508,447	2,714,002	537,079	65.00
66.00	06600	PHYSICAL THERAPY	2,047,300	29,067	594,747	2,671,114	528,592	66.00
69.00	06900	ELECTROCARDIOLOGY	931,170	262,424	318,647	1,512,241	299,260	69.00
69.01	06901	CARDIAC REHAB	167,343	42,792	56,551	266,686	52,775	69.01
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	7,846,928	0	0	7,846,928	1,552,844	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	443,781	93,436	100,009	637,226	126,102	90.00
91.00	09100	EMERGENCY	4,867,729	365,263	1,507,878	6,740,870	1,333,964	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						
95.00	09500	AMBULANCE SERVICES	1,256,078	136,920	447,512	1,840,510	364,222	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	127,197,141	11,982,610	15,232,350	124,541,778	19,578,516	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,971	43,847	9,768	97,586	19,311	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	105,712	0	36,012	141,724	28,046	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	94,920	0	0	94,920	18,784	192.05
192.06	19206	UROLOGY	1,110,783	0	108,398	1,219,181	241,266	192.06
192.08	19211	PARISH NURSING	49,996	0	12,968	62,964	12,460	192.08
192.09	19212	BIOTERRORISM GRANT	40,006	0	13,090	53,096	10,507	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	581,732	0	49,273	631,005	124,871	192.12
192.14	19210	MGH PHYS PRACT MGMT	1,602,831	0	394,718	1,997,549	395,299	192.14
192.15	19215	MGH MARION SURGEONS	2,628,518	0	202,670	2,831,188	560,269	192.15
192.16	19216	MGH MGH MED ONC	1,355,329	0	999	1,356,328	268,406	192.16
192.17	19217	MGH FMC SOUTH	3,114,371	0	299,322	3,413,693	675,543	192.17
192.18	19218	MGH FAIRM MED ASSOC	142,301	0	13,018	155,319	30,736	192.18
192.19	19219	MGH FMC MARION	765,027	0	95,175	860,202	170,227	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	1,104,603	0	128,837	1,233,440	244,088	193.01
193.02	19302	MGH FMC GAS CITY	682,457	0	79,116	761,573	150,709	193.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
193.03	19303	MGH HOSPITALISTS	3,616,836	0	0	3,616,836	715,743	193.03
193.04	19304	MGH MAR FAM PRACT	2,981,371	0	362,826	3,344,197	661,790	193.04
193.05	19305	MGH FMC SWAYZEE	236,099	0	30,348	266,447	52,728	193.05
193.06	19306	MGH PEDIATRIC CTR	1,223,041	0	95,814	1,318,855	260,991	193.06
193.07	19307	MGH SPECIALTY PHYS	320,209	0	32,715	352,924	69,841	193.07
193.08	19308	MGH FMC CONVERSE	337,534	0	47,077	384,611	76,111	193.08
193.09	19309	MGH UPLAND HEALTH	1,575,183	0	168,798	1,743,981	345,120	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	2,615,895	0	212,488	2,828,383	559,714	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	250,477	0	60,751	311,228	61,590	194.03
194.04	07953	MGH WORK SOLUTIONS	785,702	0	136,106	921,808	182,418	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	153,333	0	21,229	174,562	34,544	194.05
194.08	07957	MGH SMMP BLDG	236,179	0	0	236,179	46,738	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	6,001	0	0	6,001	1,188	194.10
194.11	07960	FAIRMOUNT	27,706	0	0	27,706	5,483	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	17,541	0	0	17,541	3,471	194.14
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	155,002,805	12,026,457	17,843,866	155,002,805	25,606,508	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
6.01	00601	CAFETERIA	0	1,905,568				6.01
6.02	00602	CAFETERIA	0	1,832,360	1,832,360			6.02
7.00	00700	OPERATION OF PLANT	0	0	46,016	10,313,782		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	113,798	734,837	8.00
9.00	00900	HOUSEKEEPING	0	0	0	175,570	14,152	9.00
10.00	01000	DIETARY	0	0	0	360,404	17,242	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	26,126	37,484	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,226	128,339	14,501	14.00
15.00	01500	PHARMACY	0	0	82,366	165,338	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	334,932	2,326,681	184,392	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	104,157	539,636	42,118	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	45,023	516,209	19,820	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	38,698	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	232,904	1,862,283	118,794	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	129,379	1,114,063	52,338	54.00
57.00	05700	CT SCAN	0	0	26,237	81,053	19,212	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	6,440	96,079	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	30,760	271,434	7,193	59.00
60.00	06000	LABORATORY	0	0	114,746	688,440	185	60.00
60.01	06001	ONCOLOGY	0	0	0	0	4,218	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	55,526	247,468	4,178	65.00
66.00	06600	PHYSICAL THERAPY	0	0	27,992	47,447	15,173	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	45,600	428,370	4,352	69.00
69.01	06901	CARDIAC REHAB	0	0	7,158	69,851	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	11,688	152,520	2,138	90.00
91.00	09100	EMERGENCY	0	0	194,000	596,239	187,713	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						
95.00	09500	AMBULANCE SERVICES	0	0	72,398	223,502	24,302	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,832,360	1,643,372	10,242,208	732,021	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,123	71,574	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	73,208	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	20,775	0	0	192.06
192.08	19211	PARISH NURSING	0	0	1,974	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	11,332	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	67,414	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	38,655	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	769	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	20,272	0	162	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	42	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	340	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	21	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	21,377	0	62	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	6,066	0	189	193.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	0	80	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	1,047	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	104	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,905,568	1,832,360	10,313,782	734,837	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	3,396,199					9.00
10.00	01000	DIETARY	49,990	1,323,246				10.00
13.00	01300	NURSING ADMINISTRATION	15,622	0	1,636,251			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,109	0	0	867,567		14.00
15.00	01500	PHARMACY	43,741	0	0	0	5,078,295	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	724,856	779,232	454,405	195,200	0	30.00
31.00	03100	INTENSIVE CARE UNIT	199,960	148,949	141,311	60,730	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	174,965	102,796	61,084	8,676	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	52,502	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	512,398	0	315,983	112,784	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,219	0	0	26,027	0	54.00
57.00	05700	CT SCAN	9,373	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	62,488	0	41,732	26,027	0	59.00
60.00	06000	LABORATORY	174,965	0	0	52,054	0	60.00
60.01	06001	ONCOLOGY	0	0	0	4,338	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	131,224	0	75,332	45,547	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	37,977	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	84,358	0	61,865	21,689	0	69.00
69.01	06901	CARDIAC REHAB	93,731	0	9,711	0	0	69.01
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	5,078,295	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,488	0	15,858	0	0	90.00
91.00	09100	EMERGENCY	749,850	14,103	263,202	60,730	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						
95.00	09500	AMBULANCE SERVICES	21,871	0	98,223	8,676	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,346,208	1,045,080	1,629,185	622,478	5,078,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,249	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	7,066	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	12,498	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	34,703	0	192.06
192.08	19211	PARISH NURSING	6,249	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	24,995	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	28,196	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	19,520	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	17,351	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	8,676	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	8,676	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	28,196	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	4,338	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	2,169	0	193.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	2,169	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	34,703	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	34,703	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	126,765	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	151,401	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	21,689	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,396,199	1,323,246	1,636,251	867,567	5,078,295	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	18,827,121	0	18,827,121		30.00
31.00	03100	INTENSIVE CARE UNIT	5,873,895	0	5,873,895		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,675,067	0	3,675,067		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	1,676,022	0	1,676,022		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	20,509,989	0	20,509,989		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,366,123	0	9,366,123		54.00
57.00	05700	CT SCAN	1,666,722	0	1,666,722		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	913,135	0	913,135		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,099,723	0	3,099,723		59.00
60.00	06000	LABORATORY	11,261,701	0	11,261,701		60.00
60.01	06001	ONCOLOGY	2,350,630	0	2,350,630		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	3,810,356	0	3,810,356		65.00
66.00	06600	PHYSICAL THERAPY	3,328,295	0	3,328,295		66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,735	0	2,457,735		69.00
69.01	06901	CARDIAC REHAB	499,912	0	499,912		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,478,067	0	14,478,067		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,008,020	0	1,008,020		90.00
91.00	09100	EMERGENCY	10,140,671	0	10,140,671		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,653,704	0	2,653,704		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,596,888	0	117,596,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195,843	0	195,843		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.02	19202	VISITOR MEALS	73,208	0	73,208		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	176,836	0	176,836		192.03
192.04	19204	LIFELINE	0	0	0		192.04
192.05	19205	OWNED PROPERTIES	126,202	0	126,202		192.05
192.06	19206	UROLOGY	1,515,925	0	1,515,925		192.06
192.08	19211	PARISH NURSING	83,647	0	83,647		192.08
192.09	19212	BIOTERRORISM GRANT	63,603	0	63,603		192.09
192.10	19214	BREAST PUMPS	0	0	0		192.10
192.12	19209	LUNG CENTER	767,208	0	767,208		192.12
192.14	19210	MGH PHYS PRACT MGMT	2,485,257	0	2,485,257		192.14
192.15	19215	MGH MARION SURGEONS	3,458,308	0	3,458,308		192.15
192.16	19216	MGH MGH MED ONC	1,624,734	0	1,624,734		192.16
192.17	19217	MGH FMC SOUTH	4,109,525	0	4,109,525		192.17
192.18	19218	MGH FAIRM MED ASSOC	186,055	0	186,055		192.18
192.19	19219	MGH FMC MARION	1,068,214	0	1,068,214		192.19
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	1,486,204	0	1,486,204		193.01
193.02	19302	MGH FMC GAS CITY	921,000	0	921,000		193.02
193.03	19303	MGH HOSPITALISTS	4,332,579	0	4,332,579		193.03
193.04	19304	MGH MAR FAM PRACT	4,034,523	0	4,034,523		193.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
193.05	19305	MGH FMC SWAYZEE	323,534	0	323,534		193.05
193.06	19306	MGH PEDIATRIC CTR	1,603,454	0	1,603,454		193.06
193.07	19307	MGH SPECIALTY PHYS	429,020	0	429,020		193.07
193.08	19308	MGH FMC CONVERSE	462,971	0	462,971		193.08
193.09	19309	MGH UPLAND HEALTH	2,124,851	0	2,124,851		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0		193.11
193.12	19312	OB/GYN	3,422,800	0	3,422,800		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0		193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07950	MOW	126,765	0	126,765		194.01
194.02	07951	MENTAL HEALTH	151,401	0	151,401		194.02
194.03	07952	ADVERTISING	372,818	0	372,818		194.03
194.04	07953	MGH WORK SOLUTIONS	1,126,019	0	1,126,019		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	209,106	0	209,106		194.05
194.08	07957	MGH SMMP BLDG	282,917	0	282,917		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	7,189	0	7,189		194.10
194.11	07960	FAIRMOUNT	33,189	0	33,189		194.11
194.12	07961	GAS CITY	0	0	0		194.12
194.13	07962	LYONS	0	0	0		194.13
194.14	07964	WABASH	21,012	0	21,012		194.14
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	155,002,805	0	155,002,805		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	459,787	459,787	459,787		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,004,080	2,004,080	84,110	2,088,190	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	160,246	160,246	0	25,672	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	0	3,083,996	3,083,996	6,433	138,327	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,714	69,714	0	8,367	8.00
9.00	00900	HOUSEKEEPING	0	107,556	107,556	0	43,198	9.00
10.00	01000	DIETARY	0	220,788	220,788	0	12,066	10.00
13.00	01300	NURSING ADMINISTRATION	0	22,963	22,963	8,430	20,976	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,622	78,622	1,375	8,560	14.00
15.00	01500	PHARMACY	0	101,288	101,288	24,198	64,488	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,425,353	1,425,353	66,766	186,283	30.00
31.00	03100	INTENSIVE CARE UNIT	0	330,588	330,588	22,512	62,470	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	316,236	316,236	8,949	37,001	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	8,510	21,351	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,140,857	1,140,857	0	233,797	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	682,488	682,488	24,307	106,268	54.00
57.00	05700	CT SCAN	0	49,654	49,654	5,046	20,624	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58,859	58,859	2,477	10,921	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	166,284	166,284	6,115	35,837	59.00
60.00	06000	LABORATORY	0	421,747	421,747	22,459	137,836	60.00
60.01	06001	ONCOLOGY	0	0	0	9,757	31,552	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	151,602	151,602	13,101	43,799	65.00
66.00	06600	PHYSICAL THERAPY	0	29,067	29,067	15,325	43,106	66.00
69.00	06900	ELECTROCARDIOLOGY	0	262,424	262,424	8,210	24,405	69.00
69.01	06901	CARDIAC REHAB	0	42,792	42,792	1,457	4,304	69.01
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	126,634	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	93,436	93,436	2,577	10,284	90.00
91.00	09100	EMERGENCY	0	365,263	365,263	38,853	108,784	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						
95.00	09500	AMBULANCE SERVICES	0	136,920	136,920	11,531	29,702	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11,982,610	11,982,610	392,498	1,596,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,847	43,847	252	1,575	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	928	2,287	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	1,532	192.05
192.06	19206	UROLOGY	0	0	0	2,793	19,675	192.06
192.08	19211	PARISH NURSING	0	0	0	334	1,016	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	337	857	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	0	1,270	10,183	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	10,170	32,236	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	5,222	45,690	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	26	21,888	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	7,712	55,090	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	335	2,507	192.18
192.19	19219	MGH FMC MARION	0	0	0	2,452	13,882	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	3,320	19,905	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	2,039	12,290	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	58,368	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
193.04	19304	MGH MAR FAM PRACT	0	0	0	9,349	53,969	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	782	4,300	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	2,469	21,284	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	843	5,695	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	1,213	6,207	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	4,349	28,144	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	5,475	45,644	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	1,565	5,023	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	3,507	14,876	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	547	2,817	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	3,811	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	97	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	447	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	283	194.14
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	12,026,457	12,026,457	459,787	2,088,190	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
6.01	00601	CAFETERIA	0	185,918				6.01
6.02	00602	CAFETERIA	0	178,775	178,775			6.02
7.00	00700	OPERATION OF PLANT	0	0	4,490	3,233,246		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	35,674	113,755	8.00
9.00	00900	HOUSEKEEPING	0	0	0	55,039	2,191	9.00
10.00	01000	DIETARY	0	0	0	112,982	2,669	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,549	11,751	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,095	40,233	2,245	14.00
15.00	01500	PHARMACY	0	0	8,036	51,831	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	32,677	729,388	28,544	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10,162	169,169	6,520	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,393	161,825	3,068	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	3,776	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	22,723	583,803	18,390	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,623	349,245	8,102	54.00
57.00	05700	CT SCAN	0	0	2,560	25,409	2,974	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	628	30,120	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	3,001	85,091	1,113	59.00
60.00	06000	LABORATORY	0	0	11,195	215,818	29	60.00
60.01	06001	ONCOLOGY	0	0	0	0	653	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	5,417	77,578	647	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,731	14,874	2,349	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,449	134,289	674	69.00
69.01	06901	CARDIAC REHAB	0	0	698	21,897	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,140	47,813	331	90.00
91.00	09100	EMERGENCY	0	0	18,928	186,914	29,058	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						
95.00	09500	AMBULANCE SERVICES	0	0	7,064	70,065	3,762	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	178,775	160,335	3,210,808	113,319	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	110	22,438	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	7,143	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	2,027	0	0	192.06
192.08	19211	PARISH NURSING	0	0	193	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	1,106	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	6,577	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	3,771	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	119	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	1,978	0	25	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	7	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	53	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	3	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	2,086	0	10	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	592	0	29	193.07

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		Cost Center Description	MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	0	12	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	162	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	16	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	185,918	178,775	3,233,246	113,755	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	207,984					9.00
10.00	01000	DIETARY	3,061	351,566				10.00
13.00	01300	NURSING ADMINISTRATION	957	0	67,626			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,783	0	0	136,913		14.00
15.00	01500	PHARMACY	2,679	0	0	0	252,520	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,390	207,031	18,781	30,803	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,246	39,573	5,840	9,584	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	10,715	27,311	2,525	1,369	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	2,170	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,379	0	13,059	17,799	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,567	0	0	4,107	0	54.00
57.00	05700	CT SCAN	574	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,827	0	1,725	4,107	0	59.00
60.00	06000	LABORATORY	10,715	0	0	8,215	0	60.00
60.01	06001	ONCOLOGY	0	0	0	685	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	8,036	0	3,113	7,188	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,570	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,166	0	2,557	3,423	0	69.00
69.01	06901	CARDIAC REHAB	5,740	0	401	0	0	69.01
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	252,520	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,827	0	655	0	0	90.00
91.00	09100	EMERGENCY	45,921	3,747	10,878	9,584	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						
95.00	09500	AMBULANCE SERVICES	1,339	0	4,060	1,369	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	204,922	277,662	67,334	98,233	252,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	383	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	292	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	765	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	5,477	0	192.06
192.08	19211	PARISH NURSING	383	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	1,531	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	4,450	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	3,081	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	2,738	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	1,369	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	1,369	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	4,450	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	685	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	342	0	193.06

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		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	342	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	5,477	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	5,477	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	33,679	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	40,225	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	3,423	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	207,984	351,566	67,626	136,913	252,520	202.00

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		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,770,016	0	2,770,016		30.00
31.00	03100	INTENSIVE CARE UNIT	668,664	0	668,664		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	573,392	0	573,392		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	35,807	0	35,807		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,061,807	0	2,061,807		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,196,707	0	1,196,707		54.00
57.00	05700	CT SCAN	106,841	0	106,841		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,005	0	103,005		58.00
59.00	05900	CARDIAC CATHETERIZATION	307,100	0	307,100		59.00
60.00	06000	LABORATORY	828,014	0	828,014		60.00
60.01	06001	ONCOLOGY	42,647	0	42,647		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	310,481	0	310,481		65.00
66.00	06600	PHYSICAL THERAPY	109,022	0	109,022		66.00
69.00	06900	ELECTROCARDIOLOGY	445,597	0	445,597		69.00
69.01	06901	CARDIAC REHAB	77,289	0	77,289		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,154	0	379,154		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	160,063	0	160,063		90.00
91.00	09100	EMERGENCY	817,930	0	817,930		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	265,812	0	265,812		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,259,348	0	11,259,348		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	68,605	0	68,605		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.02	19202	VISITOR MEALS	7,143	0	7,143		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	3,507	0	3,507		192.03
192.04	19204	LIFELINE	0	0	0		192.04
192.05	19205	OWNED PROPERTIES	2,297	0	2,297		192.05
192.06	19206	UROLOGY	29,972	0	29,972		192.06
192.08	19211	PARISH NURSING	1,926	0	1,926		192.08
192.09	19212	BIOTERRORISM GRANT	1,194	0	1,194		192.09
192.10	19214	BREAST PUMPS	0	0	0		192.10
192.12	19209	LUNG CENTER	12,559	0	12,559		192.12
192.14	19210	MGH PHYS PRACT MGMT	50,514	0	50,514		192.14
192.15	19215	MGH MARION SURGEONS	59,133	0	59,133		192.15
192.16	19216	MGH MGH MED ONC	21,914	0	21,914		192.16
192.17	19217	MGH FMC SOUTH	66,002	0	66,002		192.17
192.18	19218	MGH FAIRM MED ASSOC	2,842	0	2,842		192.18
192.19	19219	MGH FMC MARION	21,075	0	21,075		192.19
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	24,594	0	24,594		193.01
193.02	19302	MGH FMC GAS CITY	15,705	0	15,705		193.02
193.03	19303	MGH HOSPITALISTS	58,368	0	58,368		193.03
193.04	19304	MGH MAR FAM PRACT	67,821	0	67,821		193.04

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		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
193.05	19305	MGH FMC SWAYZEE	5,770	0	5,770		193.05
193.06	19306	MGH PEDIATRIC CTR	26,191	0	26,191		193.06
193.07	19307	MGH SPECIALTY PHYS	7,159	0	7,159		193.07
193.08	19308	MGH FMC CONVERSE	7,774	0	7,774		193.08
193.09	19309	MGH UPLAND HEALTH	38,132	0	38,132		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0		193.11
193.12	19312	OB/GYN	56,596	0	56,596		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0		193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07950	MOW	33,679	0	33,679		194.01
194.02	07951	MENTAL HEALTH	40,225	0	40,225		194.02
194.03	07952	ADVERTISING	6,588	0	6,588		194.03
194.04	07953	MGH WORK SOLUTIONS	21,822	0	21,822		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	3,364	0	3,364		194.05
194.08	07957	MGH SMMP BLDG	3,811	0	3,811		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	97	0	97		194.10
194.11	07960	FAIRMOUNT	447	0	447		194.11
194.12	07961	GAS CITY	0	0	0		194.12
194.13	07962	LYONS	0	0	0		194.13
194.14	07964	WABASH	283	0	283		194.14
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	12,026,457	0	12,026,457		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			1.00	4.00	5A	5.00	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	364,518					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,936	46,516,851				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,743	8,508,274	-25,606,508	129,396,297		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	289,839	6.00
6.01	00601	CAFETERIA	4,857	0	0	1,590,768	4,857	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	93,475	650,864	0	8,571,529	93,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,113	0	0	518,443	2,113	8.00
9.00	00900	HOUSEKEEPING	3,260	0	0	2,676,766	3,260	9.00
10.00	01000	DIETARY	6,692	0	0	747,655	6,692	10.00
13.00	01300	NURSING ADMINISTRATION	696	852,919	0	1,299,799	696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,383	139,066	0	530,425	2,383	14.00
15.00	01500	PHARMACY	3,070	2,448,178	0	3,996,061	3,070	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,202	6,754,999	0	11,543,130	43,202	30.00
31.00	03100	INTENSIVE CARE UNIT	10,020	2,277,576	0	3,870,995	10,020	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,585	905,393	0	2,292,773	9,585	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	860,988	0	1,323,009	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,579	0	0	14,487,804	34,579	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,686	2,459,277	0	6,584,982	20,686	54.00
57.00	05700	CT SCAN	1,505	510,534	0	1,277,951	1,505	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,784	250,638	0	676,702	1,784	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,040	618,665	0	2,220,642	5,040	59.00
60.00	06000	LABORATORY	12,783	2,272,208	0	8,541,096	12,783	60.00
60.01	06001	ONCOLOGY	0	987,181	0	1,955,163	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	4,595	1,325,461	0	2,714,002	4,595	65.00
66.00	06600	PHYSICAL THERAPY	881	1,550,436	0	2,671,114	881	66.00
69.00	06900	ELECTROCARDIOLOGY	7,954	830,674	0	1,512,241	7,954	69.00
69.01	06901	CARDIAC REHAB	1,297	147,423	0	266,686	1,297	69.01
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	7,846,928	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,832	260,712	0	637,226	2,832	90.00
91.00	09100	EMERGENCY	11,071	3,930,860	0	6,740,870	11,071	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						
95.00	09500	AMBULANCE SERVICES	4,150	1,166,610	0	1,840,510	4,150	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	363,189	39,708,936	-25,606,508	98,935,270	288,510	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,329	25,464	0	97,586	1,329	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	93,878	0	141,724	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	94,920	0	192.05
192.06	19206	UROLOGY	0	282,582	0	1,219,181	0	192.06
192.08	19211	PARISH NURSING	0	33,806	0	62,964	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	34,125	0	53,096	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	128,448	0	631,005	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	1,028,983	0	1,997,549	0	192.14
192.15	19215	MGH MARION SURGEONS	0	528,336	0	2,831,188	0	192.15
192.16	19216	MGH MGH MED ONC	0	2,603	0	1,356,328	0	192.16
192.17	19217	MGH FMC SOUTH	0	780,298	0	3,413,693	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	33,936	0	155,319	0	192.18
192.19	19219	MGH FMC MARION	0	248,111	0	860,202	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	335,863	0	1,233,440	0	193.01
193.02	19302	MGH FMC GAS CITY	0	206,246	0	761,573	0	193.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			1.00	4.00	5A	5.00	6.00	
193.03	19303	MGH HOSPITALISTS	0	0	0	3,616,836	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	945,845	0	3,344,197	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	79,114	0	266,447	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	249,777	0	1,318,855	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	85,283	0	352,924	0	193.07
193.08	19308	MGH FMC CONVERSE	0	122,724	0	384,611	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	440,036	0	1,743,981	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	553,931	0	2,828,383	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	158,372	0	311,228	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	354,812	0	921,808	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	55,342	0	174,562	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	236,179	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	6,001	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	27,706	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	17,541	0	194.14
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)	12,026,457	17,843,866		25,606,508	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.992766	0.383600		0.197892	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		459,787		2,088,190	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.009884		0.016138	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA	262,377					6.01
6.02	00602	CAFETERIA	252,297	1,358,088				6.02
7.00	00700	OPERATION OF PLANT	0	34,106	191,507			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,113	746,697		8.00
9.00	00900	HOUSEKEEPING	0	0	3,260	14,380	56,524	9.00
10.00	01000	DIETARY	0	0	6,692	17,520	832	10.00
13.00	01300	NURSING ADMINISTRATION	0	19,364	696	0	260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,320	2,383	14,735	1,300	14.00
15.00	01500	PHARMACY	0	61,047	3,070	0	728	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	248,241	43,202	187,368	12,064	30.00
31.00	03100	INTENSIVE CARE UNIT	0	77,198	10,020	42,798	3,328	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	33,370	9,585	20,140	2,912	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	28,682	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	172,621	34,579	120,711	8,528	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,892	20,686	53,183	2,600	54.00
57.00	05700	CT SCAN	0	19,446	1,505	19,522	156	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,773	1,784	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,798	5,040	7,309	1,040	59.00
60.00	06000	LABORATORY	0	85,046	12,783	188	2,912	60.00
60.01	06001	ONCOLOGY	0	0	0	4,286	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	41,154	4,595	4,245	2,184	65.00
66.00	06600	PHYSICAL THERAPY	0	20,747	881	15,418	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	33,797	7,954	4,422	1,404	69.00
69.01	06901	CARDIAC REHAB	0	5,305	1,297	0	1,560	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,663	2,832	2,172	1,040	90.00
91.00	09100	EMERGENCY	0	143,787	11,071	190,745	12,480	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						
95.00	09500	AMBULANCE SERVICES	0	53,659	4,150	24,694	364	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	252,297	1,218,016	190,178	743,836	55,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	832	1,329	0	104	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	10,080	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	208	192.05
192.06	19206	UROLOGY	0	15,398	0	0	0	192.06
192.08	19211	PARISH NURSING	0	1,463	0	0	104	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	0	8,399	0	0	0	192.12
192.14	19210	MGH PHYS PRACT MGMT	0	49,965	0	0	416	192.14
192.15	19215	MGH MARION SURGEONS	0	28,650	0	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	781	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	15,025	0	165	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	43	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	345	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	21	0	193.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
193.06	19306	MGH PEDIATRIC CTR	0	15,844	0	63	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	4,496	0	192	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	81	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	1,064	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	106	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
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)	1,905,568	1,832,360	10,313,782	734,837	3,396,199	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.262710	1.349220	53.855901	0.984117	60.084194	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	185,918	178,775	3,233,246	113,755	207,984	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.708591	0.131637	16.883174	0.152344	3.679570	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
			10.00	13.00	14.00	15.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	91,202					10.00
13.00	01300	NURSING ADMINISTRATION	0	893,882				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	10,000			14.00
15.00	01500	PHARMACY	0	0	0	100		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,707	248,241	2,250	0		30.00
31.00	03100	INTENSIVE CARE UNIT	10,266	77,198	700	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	7,085	33,370	100	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	28,682	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	172,621	1,300	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	300	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,798	300	0		59.00
60.00	06000	LABORATORY	0	0	600	0		60.00
60.01	06001	ONCOLOGY	0	0	50	0		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	0	41,154	525	0		65.00
66.00	06600	PHYSICAL THERAPY	0	20,747	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	33,797	250	0		69.00
69.01	06901	CARDIAC REHAB	0	5,305	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	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	0	0	0	100		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,663	0	0		90.00
91.00	09100	EMERGENCY	972	143,787	700	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	53,659	100	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,030	890,022	7,175	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.02	19202	VISITOR MEALS	0	0	0	0		192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	3,860	0	0		192.03
192.04	19204	LIFELINE	0	0	0	0		192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0		192.05
192.06	19206	UROLOGY	0	0	400	0		192.06
192.08	19211	PARISH NURSING	0	0	0	0		192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0		192.09
192.10	19214	BREAST PUMPS	0	0	0	0		192.10
192.12	19209	LUNG CENTER	0	0	0	0		192.12
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	0		192.14
192.15	19215	MGH MARION SURGEONS	0	0	325	0		192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0		192.16
192.17	19217	MGH FMC SOUTH	0	0	225	0		192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0		192.18
192.19	19219	MGH FMC MARION	0	0	200	0		192.19
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	100	0		193.01
193.02	19302	MGH FMC GAS CITY	0	0	100	0		193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0		193.03
193.04	19304	MGH MAR FAM PRACT	0	0	325	0		193.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 9:19 am

		Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
			10.00	13.00	14.00	15.00		
193.05	19305	MGH FMC SWAYZEE	0	0	50	0		193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	25	0		193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0		193.07
193.08	19308	MGH FMC CONVERSE	0	0	25	0		193.08
193.09	19309	MGH UPLAND HEALTH	0	0	400	0		193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0		193.11
193.12	19312	OB/GYN	0	0	400	0		193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0		193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0		194.00
194.01	07950	MOW	8,737	0	0	0		194.01
194.02	07951	MENTAL HEALTH	10,435	0	0	0		194.02
194.03	07952	ADVERTISING	0	0	0	0		194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	250	0		194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0		194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0		194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0		194.10
194.11	07960	FAIRMOUNT	0	0	0	0		194.11
194.12	07961	GAS CITY	0	0	0	0		194.12
194.13	07962	LYONS	0	0	0	0		194.13
194.14	07964	WABASH	0	0	0	0		194.14
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)	1,323,246	1,636,251	867,567	5,078,295		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.508958	1.830500	86.756700	50,782.950000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	351,566	67,626	136,913	252,520		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.854806	0.075654	13.691300	2,525.200000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,827,121		18,827,121	0	18,827,121	30.00
31.00	03100	INTENSIVE CARE UNIT	5,873,895		5,873,895	0	5,873,895	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,675,067		3,675,067	0	3,675,067	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,676,022		1,676,022	0	1,676,022	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,509,989		20,509,989	0	20,509,989	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,366,123		9,366,123	0	9,366,123	54.00
57.00	05700	CT SCAN	1,666,722		1,666,722	0	1,666,722	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	913,135		913,135	0	913,135	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,099,723		3,099,723	0	3,099,723	59.00
60.00	06000	LABORATORY	11,261,701		11,261,701	0	11,261,701	60.00
60.01	06001	ONCOLOGY	2,350,630		2,350,630	0	2,350,630	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,810,356	0	3,810,356	0	3,810,356	65.00
66.00	06600	PHYSICAL THERAPY	3,328,295	0	3,328,295	0	3,328,295	66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,735		2,457,735	0	2,457,735	69.00
69.01	06901	CARDIAC REHAB	499,912		499,912	0	499,912	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	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	14,478,067		14,478,067	0	14,478,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,008,020		1,008,020	0	1,008,020	90.00
91.00	09100	EMERGENCY	10,140,671		10,140,671	0	10,140,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,004,548		3,004,548		3,004,548	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,653,704		2,653,704	0	2,653,704	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	120,601,436	0	120,601,436	0	120,601,436	200.00
201.00		Less Observation Beds	3,004,548		3,004,548		3,004,548	201.00
202.00		Total (see instructions)	117,596,888	0	117,596,888	0	117,596,888	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,245,682		18,245,682			30.00
31.00	03100	INTENSIVE CARE UNIT	8,172,550		8,172,550			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,198,993		3,198,993			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,176,776		2,176,776			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,533,910	71,276,146	111,810,056	0.183436	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,797,229	28,491,606	30,288,835	0.309227	0.000000	54.00
57.00	05700	CT SCAN	4,220,572	27,983,196	32,203,768	0.051755	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	308,369	3,270,083	3,578,452	0.255176	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,299,811	5,428,742	8,728,553	0.355124	0.000000	59.00
60.00	06000	LABORATORY	3,281,672	12,260,020	15,541,692	0.724612	0.000000	60.00
60.01	06001	ONCOLOGY	30,234	6,716,535	6,746,769	0.348408	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,855,461	5,667,468	8,522,929	0.447071	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,089,805	5,582,023	10,671,828	0.311877	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,684,813	7,296,032	10,980,845	0.223820	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	864,303	864,303	0.578399	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	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	8,135,724	67,591,035	75,726,759	0.191188	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	762,709	762,709	1.321631	0.000000	90.00
91.00	09100	EMERGENCY	9,626,507	57,961,092	67,587,599	0.150037	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	400,000	5,187,012	5,587,012	0.537774	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,357,674	5,357,674	0.495309	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	115,058,108	311,695,676	426,753,784			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	115,058,108	311,695,676	426,753,784			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.183436		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309227		54.00
57.00	05700	CT SCAN	0.051755		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.255176		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.355124		59.00
60.00	06000	LABORATORY	0.724612		60.00
60.01	06001	ONCOLOGY	0.348408		60.01
60.02	06002	RADIATION ONCOLOGY	0.000000		60.02
65.00	06500	RESPIRATORY THERAPY	0.447071		65.00
66.00	06600	PHYSICAL THERAPY	0.311877		66.00
69.00	06900	ELECTROCARDIOLOGY	0.223820		69.00
69.01	06901	CARDIAC REHAB	0.578399		69.01
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	0.191188		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.321631		90.00
91.00	09100	EMERGENCY	0.150037		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537774		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.495309		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 9:19 am

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	18,827,121		18,827,121	0	18,827,121	30.00
31.00	03100	INTENSIVE CARE UNIT	5,873,895		5,873,895	0	5,873,895	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,675,067		3,675,067	0	3,675,067	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,676,022		1,676,022	0	1,676,022	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,509,989		20,509,989	0	20,509,989	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,366,123		9,366,123	0	9,366,123	54.00
57.00	05700	CT SCAN	1,666,722		1,666,722	0	1,666,722	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	913,135		913,135	0	913,135	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,099,723		3,099,723	0	3,099,723	59.00
60.00	06000	LABORATORY	11,261,701		11,261,701	0	11,261,701	60.00
60.01	06001	ONCOLOGY	2,350,630		2,350,630	0	2,350,630	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,810,356	0	3,810,356	0	3,810,356	65.00
66.00	06600	PHYSICAL THERAPY	3,328,295	0	3,328,295	0	3,328,295	66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,735		2,457,735	0	2,457,735	69.00
69.01	06901	CARDIAC REHAB	499,912		499,912	0	499,912	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	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	14,478,067		14,478,067	0	14,478,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,008,020		1,008,020	0	1,008,020	90.00
91.00	09100	EMERGENCY	10,140,671		10,140,671	0	10,140,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,004,548		3,004,548		3,004,548	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,653,704		2,653,704	0	2,653,704	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	120,601,436	0	120,601,436	0	120,601,436	200.00
201.00		Less Observation Beds	3,004,548		3,004,548		3,004,548	201.00
202.00		Total (see instructions)	117,596,888	0	117,596,888	0	117,596,888	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 9:19 am

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	18,245,682		18,245,682			30.00
31.00	03100	INTENSIVE CARE UNIT	8,172,550		8,172,550			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,198,993		3,198,993			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,176,776		2,176,776			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,533,910	71,276,146	111,810,056	0.183436	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,797,229	28,491,606	30,288,835	0.309227	0.000000	54.00
57.00	05700	CT SCAN	4,220,572	27,983,196	32,203,768	0.051755	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	308,369	3,270,083	3,578,452	0.255176	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,299,811	5,428,742	8,728,553	0.355124	0.000000	59.00
60.00	06000	LABORATORY	3,281,672	12,260,020	15,541,692	0.724612	0.000000	60.00
60.01	06001	ONCOLOGY	30,234	6,716,535	6,746,769	0.348408	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,855,461	5,667,468	8,522,929	0.447071	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,089,805	5,582,023	10,671,828	0.311877	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,684,813	7,296,032	10,980,845	0.223820	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	864,303	864,303	0.578399	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	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	8,135,724	67,591,035	75,726,759	0.191188	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	762,709	762,709	1.321631	0.000000	90.00
91.00	09100	EMERGENCY	9,626,507	57,961,092	67,587,599	0.150037	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	400,000	5,187,012	5,587,012	0.537774	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,357,674	5,357,674	0.495309	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	115,058,108	311,695,676	426,753,784			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	115,058,108	311,695,676	426,753,784			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 9:19 am

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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	ONCOLOGY	0.000000		60.01
60.02	06002	RADIATION ONCOLOGY	0.000000		60.02
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,770,016	0	2,770,016	17,301	160.11	30.00
31.00	INTENSIVE CARE UNIT	668,664		668,664	4,075	164.09	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	573,392	0	573,392	2,433	235.67	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	35,807		35,807	1,850	19.36	43.00
200.00	Total (lines 30-199)	4,047,879		4,047,879	25,659		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	7,503	1,201,305	30.00
31.00	INTENSIVE CARE UNIT	1,643	269,600	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	1,951	459,792	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	11,097	1,930,697	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,061,807	111,810,056	0.018440	17,129,819	315,874	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,196,707	30,288,835	0.039510	949,767	37,525	54.00
57.00	05700	CT SCAN	106,841	32,203,768	0.003318	2,423,329	8,041	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,005	3,578,452	0.028785	171,107	4,925	58.00
59.00	05900	CARDIAC CATHETERIZATION	307,100	8,728,553	0.035183	2,601,510	91,529	59.00
60.00	06000	LABORATORY	828,014	15,541,692	0.053277	1,721,472	91,715	60.00
60.01	06001	ONCOLOGY	42,647	6,746,769	0.006321	28,793	182	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	310,481	8,522,929	0.036429	1,493,313	54,400	65.00
66.00	06600	PHYSICAL THERAPY	109,022	10,671,828	0.010216	1,520,914	15,538	66.00
69.00	06900	ELECTROCARDIOLOGY	445,597	10,980,845	0.040579	1,020,527	41,412	69.00
69.01	06901	CARDIAC REHAB	77,289	864,303	0.089424	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	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	379,154	75,726,759	0.005007	4,124,992	20,654	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	160,063	762,709	0.209861	0	0	90.00
91.00	09100	EMERGENCY	817,930	67,587,599	0.012102	4,704,101	56,929	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	442,056	5,587,012	0.079122	339,502	26,862	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	7,387,713	389,602,109		38,229,146	765,586	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,301	0.00	7,503	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,075	0.00	1,643	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	2,433	0.00	1,951	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	1,850	0.00	0	0		43.00
200.00		Total (lines 30-199)	25,659		11,097	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,810,056	0.000000	0.000000	17,129,819	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,288,835	0.000000	0.000000	949,767	54.00
57.00	05700	CT SCAN	0	32,203,768	0.000000	0.000000	2,423,329	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,578,452	0.000000	0.000000	171,107	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,728,553	0.000000	0.000000	2,601,510	59.00
60.00	06000	LABORATORY	0	15,541,692	0.000000	0.000000	1,721,472	60.00
60.01	06001	ONCOLOGY	0	6,746,769	0.000000	0.000000	28,793	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	8,522,929	0.000000	0.000000	1,493,313	65.00
66.00	06600	PHYSICAL THERAPY	0	10,671,828	0.000000	0.000000	1,520,914	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,980,845	0.000000	0.000000	1,020,527	69.00
69.01	06901	CARDIAC REHAB	0	864,303	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75,726,759	0.000000	0.000000	4,124,992	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	762,709	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	67,587,599	0.000000	0.000000	4,704,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,587,012	0.000000	0.000000	339,502	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	389,602,109			38,229,146	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	18,870,282	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,480,869	0		54.00
57.00	05700	CT SCAN	0	8,493,888	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,018,893	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,639,326	0		59.00
60.00	06000	LABORATORY	0	1,808,986	0		60.00
60.01	06001	ONCOLOGY	0	2,932,940	0		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	0	1,075,690	0		65.00
66.00	06600	PHYSICAL THERAPY	0	41,373	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,527,862	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,806,802	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	299,386	0		90.00
91.00	09100	EMERGENCY	0	12,107,638	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,215,319	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	93,319,254	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.183436	18,870,282	0	0	3,461,489	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309227	8,480,869	0	0	2,622,514	54.00
57.00	05700	CT SCAN	0.051755	8,493,888	0	0	439,601	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.255176	1,018,893	0	0	259,997	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.355124	2,639,326	0	0	937,288	59.00
60.00	06000	LABORATORY	0.724612	1,808,986	0	0	1,310,813	60.00
60.01	06001	ONCOLOGY	0.348408	2,932,940	0	0	1,021,860	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.447071	1,075,690	0	0	480,910	65.00
66.00	06600	PHYSICAL THERAPY	0.311877	41,373	0	0	12,903	66.00
69.00	06900	ELECTROCARDIOLOGY	0.223820	2,527,862	0	0	565,786	69.00
69.01	06901	CARDIAC REHAB	0.578399	0	0	0	0	69.01
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	0.191188	31,806,802	0	6,289	6,081,079	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.321631	299,386	0	0	395,678	90.00
91.00	09100	EMERGENCY	0.150037	12,107,638	0	0	1,816,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537774	1,215,319	0	0	653,567	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.495309		0			95.00
200.00		Subtotal (see instructions)		93,319,254	0	6,289	20,060,079	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		93,319,254	0	6,289	20,060,079	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	ONCOLOGY	0	0		60.01
60.02	06002	RADIATION ONCOLOGY	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
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	1,202		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,202		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,202		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,061,807	111,810,056	0.018440	34,331	633	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,196,707	30,288,835	0.039510	31,443	1,242	54.00
57.00	05700	CT SCAN	106,841	32,203,768	0.003318	56,544	188	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,005	3,578,452	0.028785	4,000	115	58.00
59.00	05900	CARDIAC CATHETERIZATION	307,100	8,728,553	0.035183	10,723	377	59.00
60.00	06000	LABORATORY	828,014	15,541,692	0.053277	56,393	3,004	60.00
60.01	06001	ONCOLOGY	42,647	6,746,769	0.006321	479	3	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	310,481	8,522,929	0.036429	84,876	3,092	65.00
66.00	06600	PHYSICAL THERAPY	109,022	10,671,828	0.010216	2,052,789	20,971	66.00
69.00	06900	ELECTROCARDIOLOGY	445,597	10,980,845	0.040579	19,271	782	69.00
69.01	06901	CARDIAC REHAB	77,289	864,303	0.089424	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	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	379,154	75,726,759	0.005007	221,887	1,111	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	160,063	762,709	0.209861	0	0	90.00
91.00	09100	EMERGENCY	817,930	67,587,599	0.012102	57,783	699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,587,012	0.000000	41,847	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,945,657	389,602,109		2,672,366	32,217	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,810,056	0.000000	0.000000	34,331	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,288,835	0.000000	0.000000	31,443	54.00
57.00	05700	CT SCAN	0	32,203,768	0.000000	0.000000	56,544	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,578,452	0.000000	0.000000	4,000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,728,553	0.000000	0.000000	10,723	59.00
60.00	06000	LABORATORY	0	15,541,692	0.000000	0.000000	56,393	60.00
60.01	06001	ONCOLOGY	0	6,746,769	0.000000	0.000000	479	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	8,522,929	0.000000	0.000000	84,876	65.00
66.00	06600	PHYSICAL THERAPY	0	10,671,828	0.000000	0.000000	2,052,789	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,980,845	0.000000	0.000000	19,271	69.00
69.01	06901	CARDIAC REHAB	0	864,303	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75,726,759	0.000000	0.000000	221,887	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	762,709	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	67,587,599	0.000000	0.000000	57,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,587,012	0.000000	0.000000	41,847	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	389,602,109			2,672,366	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	ONCOLOGY	0	0	0		60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0		60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,301	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,301	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)	14,540	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,503	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	18,827,121	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,827,121	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)	18,827,121	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,088.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,164,840	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)	8,164,840	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,873,895	4,075	1,441.45	1,643	2,368,302	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)	8,833,672	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	19,366,814	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)	1,470,905	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	765,586	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,236,491	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	17,130,323	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,761	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,088.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,004,548	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

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	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	2,770,016	18,827,121	0.147129	3,004,548	442,056	90.00
91.00	Nursing School cost	0	18,827,121	0.000000	3,004,548	0	91.00
92.00	Allied health cost	0	18,827,121	0.000000	3,004,548	0	92.00
93.00	All other Medical Education	0	18,827,121	0.000000	3,004,548	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 9:19 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,433	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,433	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)	2,433	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,951	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,675,067	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,675,067	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)	3,675,067	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,510.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,947,005	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,947,005	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	820,879	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,767,884	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)	459,792	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	32,217	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	492,009	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,275,875	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	573,392	3,675,067	0.156022	0	0	90.00
91.00	Nursing School cost	0	3,675,067	0.000000	0	0	91.00
92.00	Allied health cost	0	3,675,067	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,675,067	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

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)	17,301	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,301	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)	14,540	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	478	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)	1,850	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	18,827,121	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,827,121	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)	18,827,121	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,088.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	520,164	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)	520,164	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

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)	1,676,022	1,850	905.96	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,873,895	4,075	1,441.45	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)	225,589	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	745,753	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)	2,761	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,088.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,004,548	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

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	2,770,016	18,827,121	0.147129	3,004,548	442,056	90.00
91.00	Nursing School cost	0	18,827,121	0.000000	3,004,548	0	91.00
92.00	Allied health cost	0	18,827,121	0.000000	3,004,548	0	92.00
93.00	All other Medical Education	0	18,827,121	0.000000	3,004,548	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 9:19 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,433	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,433	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)	2,433	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11	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)	1,850	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,675,067	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,675,067	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)	3,675,067	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,510.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,616	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)	16,616	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,616	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 9:19 am

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	573,392	3,675,067	0.156022	0	0	90.00
91.00	Nursing School cost	0	3,675,067	0.000000	0	0	91.00
92.00	Allied health cost	0	3,675,067	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,675,067	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,823,528		30.00
31.00	03100	INTENSIVE CARE UNIT		3,673,636		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.183436	17,129,819	3,142,225	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309227	949,767	293,694	54.00
57.00	05700	CT SCAN	0.051755	2,423,329	125,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.255176	171,107	43,662	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.355124	2,601,510	923,859	59.00
60.00	06000	LABORATORY	0.724612	1,721,472	1,247,399	60.00
60.01	06001	ONCOLOGY	0.348408	28,793	10,032	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.447071	1,493,313	667,617	65.00
66.00	06600	PHYSICAL THERAPY	0.311877	1,520,914	474,338	66.00
69.00	06900	ELECTROCARDIOLOGY	0.223820	1,020,527	228,414	69.00
69.01	06901	CARDIAC REHAB	0.578399	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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	0.191188	4,124,992	788,649	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.321631	0	0	90.00
91.00	09100	EMERGENCY	0.150037	4,704,101	705,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537774	339,502	182,575	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		38,229,146	8,833,672	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)		38,229,146		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		2,569,259		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.183436	34,331	6,298	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309227	31,443	9,723	54.00
57.00	05700	CT SCAN	0.051755	56,544	2,926	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.255176	4,000	1,021	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.355124	10,723	3,808	59.00
60.00	06000	LABORATORY	0.724612	56,393	40,863	60.00
60.01	06001	ONCOLOGY	0.348408	479	167	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.447071	84,876	37,946	65.00
66.00	06600	PHYSICAL THERAPY	0.311877	2,052,789	640,218	66.00
69.00	06900	ELECTROCARDIOLOGY	0.223820	19,271	4,313	69.00
69.01	06901	CARDIAC REHAB	0.578399	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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	0.191188	221,887	42,422	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.321631	0	0	90.00
91.00	09100	EMERGENCY	0.150037	57,783	8,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537774	41,847	22,504	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,672,366	820,879	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,672,366		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 9:19 am

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		584,470		30.00
31.00	03100	INTENSIVE CARE UNIT		120,614		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.183436	479,564	87,969	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309227	25,595	7,915	54.00
57.00	05700	CT SCAN	0.051755	37,840	1,958	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.255176	3,113	794	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.355124	32,099	11,399	59.00
60.00	06000	LABORATORY	0.724612	62,994	45,646	60.00
60.01	06001	ONCOLOGY	0.348408	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.447071	31,231	13,962	65.00
66.00	06600	PHYSICAL THERAPY	0.311877	12,199	3,805	66.00
69.00	06900	ELECTROCARDIOLOGY	0.223820	39,665	8,878	69.00
69.01	06901	CARDIAC REHAB	0.578399	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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	0.191188	111,659	21,348	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.321631	0	0	90.00
91.00	09100	EMERGENCY	0.150037	146,067	21,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537774	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		982,026	225,589	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)		982,026		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,575,254	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12,027,043	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	247,015	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	91.44	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.21	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.66	31.00
32.00	Sum of lines 30 and 31	28.87	32.00
33.00	Allowable disproportionate share percentage (see instructions)	13.04	33.00
34.00	Disproportionate share adjustment (see instructions)	508,635	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 9:19 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000148874	0.000142355	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	953,709	850,925	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	239,730	636,445	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	876,175		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	17,234,122		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	17,268,851		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	17,268,851	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,314,930	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	18,583,781	59.00
60.00	Primary payer payments	3,289	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	18,580,492	61.00
62.00	Deductibles billed to program beneficiaries	2,066,624	62.00
63.00	Coinsurance billed to program beneficiaries	19,537	63.00
64.00	Allowable bad debts (see instructions)	171,698	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	111,604	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,921	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,605,935	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	46,544	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 9:19 am
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		143,439	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,509,040	71.00
71.01	Sequestration adjustment (see instructions)		330,181	71.01
72.00	Interim payments		16,958,401	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-779,542	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		311,687	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2017 9:19 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,575,254	0	3,575,254		3,575,254	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,027,043	0		12,027,043	12,027,043	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	247,015	0	46,485	200,530	247,015	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1304	0.1304	0.1304	0.1304		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	508,635	0	116,553	392,082	508,635	11.00
11.01	Uncompensated care payments	36.00	876,175	0	239,730	636,445	876,175	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,234,122	0	3,978,022	13,256,100	17,234,122	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	17,268,851	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,268,851	0	3,978,022	13,290,829	17,268,851	15.00
16.00	Payment for inpatient program capital	50.00	1,314,930	0	296,523	1,018,407	1,314,930	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2017 9:19 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,274,545	14,309,236	18,583,781	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,260,261	0	286,429	973,832	1,260,261	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	54,669	0	10,094	44,575	54,669	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,314,930	0	296,523	1,018,407	1,314,930	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2017 9:19 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,575,254	3,575,254		3,575,254	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,027,043		12,027,043	12,027,043	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	247,015	46,485	200,530	247,015	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1304	0.1304	0.1304		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	508,635	116,553	392,082	508,635	11.00
11.01	Uncompensated care payments	36.00	876,175	239,730	636,445	876,175	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,234,122	3,978,022	13,256,100	17,234,122	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	17,268,851	3,966,999	13,301,852	17,268,851	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,268,851	3,978,022	13,290,829	17,268,851	15.00
16.00	Payment for inpatient program capital	50.00	1,314,930	296,523	1,018,407	1,314,930	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,274,545	14,309,236	18,583,781	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2017 9:19 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,260,261	286,429	973,832	1,260,261	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	54,669	10,094	44,575	54,669	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,314,930	296,523	1,018,407	1,314,930	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	46,544	11,875	34,669	46,544	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	143,439	143,439	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 9:19 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,202	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20,060,079	2.00
3.00	PPS payments	17,554,540	3.00
4.00	Outlier payment (see instructions)	246,825	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,202	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,289	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	6,289	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	6,289	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,087	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,202	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	17,801,365	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,587,598	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)	14,214,969	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)	14,214,969	30.00
31.00	Primary payer payments	3,087	31.00
32.00	Subtotal (line 30 minus line 31)	14,211,882	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)	881,885	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	573,225	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	578,153	36.00
37.00	Subtotal (see instructions)	14,785,107	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-13	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	29,121	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	14,785,120	40.00
40.01	Sequestration adjustment (see instructions)	295,702	40.01
41.00	Interim payments	14,526,388	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-36,970	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2017 9:19 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16,840,570		13,927,100	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	06/28/2017	89,331	06/28/2017	599,288	3.01
3.02		01/13/2017	28,500		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)		117,831		599,288	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,958,401		14,526,388	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		779,542		36,970	6.02
7.00	Total Medicare program liability (see instructions)		16,178,859		14,489,418	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: 15-0011 | Component CCN: 15-T011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2017 9:19 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,132,881		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)		3,132,881		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		4,841		0	6.02
7.00	Total Medicare program liability (see instructions)		3,128,040		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: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/28/2017 9:19 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	4,932	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	9,146	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,451	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	18,615	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	426,753,784	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	12,170,849	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	441,952	8.00
9.00	Sequestration adjustment amount (see instructions)	8,839	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	433,113	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	431,696	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1,417	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part III Date/Time Prepared: 11/28/2017 9:19 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,114,300	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0229	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	69,137	3.00
4.00	Outlier Payments	58,799	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	6.665753	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,242,236	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,242,236	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,242,236	19.00
20.00	Deductibles	48,104	20.00
21.00	Subtotal (line 19 minus line 20)	3,194,132	21.00
22.00	Coinsurance	2,254	22.00
23.00	Subtotal (line 21 minus line 22)	3,191,878	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,191,878	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,191,878	32.00
32.01	Sequestration adjustment (see instructions)	63,838	32.01
33.00	Interim payments	3,132,881	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-4,841	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	25,360	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	58,799	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2017 9:19 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	745,753		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	745,753	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	745,753	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	705,084		8.00
9.00	Ancillary service charges	982,026	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,687,110	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,687,110	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	941,357	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	745,753	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	745,753	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	745,753	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	745,753	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	745,753	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	745,753	0	40.00
41.00	Interim payments	797,688	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-51,935	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2017 9:19 am
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	16,616		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	16,616	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	16,616	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	16,616	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	16,616	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/28/2017 9:19 am

		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	27,856,077	0	0	0	1.00
2.00	Temporary investments	2,720,934	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	64,134,739	0	0	0	4.00
5.00	Other receivable	2,255,880	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-41,242,408	0	0	0	6.00
7.00	Inventory	1,412,517	0	0	0	7.00
8.00	Prepaid expenses	2,848,967	0	0	0	8.00
9.00	Other current assets	1,004,558	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)	60,991,264	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,646,548	0	0	0	12.00
13.00	Land improvements	3,353,531	0	0	0	13.00
14.00	Accumulated depreciation	-2,391,371	0	0	0	14.00
15.00	Buildings	122,368,872	0	0	0	15.00
16.00	Accumulated depreciation	-69,090,090	0	0	0	16.00
17.00	Leasehold improvements	3,287,382	0	0	0	17.00
18.00	Accumulated depreciation	-1,389,278	0	0	0	18.00
19.00	Fixed equipment	1,144,744	0	0	0	19.00
20.00	Accumulated depreciation	-728,862	0	0	0	20.00
21.00	Automobiles and trucks	1,024,345	0	0	0	21.00
22.00	Accumulated depreciation	-603,641	0	0	0	22.00
23.00	Major movable equipment	68,548,863	0	0	0	23.00
24.00	Accumulated depreciation	-54,198,296	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	10,088,797	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	86,061,544	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	219,186,714	10,155	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	7,802,316	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	226,989,030	10,155	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	374,041,838	10,155	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,739,862	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,246,238	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,236,777	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,222,877	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	85,834,889	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	85,834,889	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	108,057,766	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	265,984,072				52.00
53.00	Specific purpose fund		10,155			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)	265,984,072	10,155	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	374,041,838	10,155	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/28/2017 9:19 am

		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		240,170,316		10,155		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		25,813,756				2.00
3.00	Total (sum of line 1 and line 2)		265,984,072		10,155		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)		265,984,072		10,155		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		265,984,072		10,155		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2017 9:19 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	19,496,904		19,496,904	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,198,993		3,198,993	3.00
4.00	SUBPROVIDER	0		0	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)	22,695,897		22,695,897	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,172,550		8,172,550	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)	8,172,550		8,172,550	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,868,447		30,868,447	17.00
18.00	Ancillary services	84,556,634	0	84,556,634	18.00
19.00	Outpatient services	0	310,651,914	310,651,914	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	5,375,369	5,375,369	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	28,666,233	28,666,233	27.00
27.01		0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	115,425,081	344,693,516	460,118,597	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		172,500,359		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	ELIMINATIONS	1,026,156			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		1,026,156		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		171,474,203		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0011 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 | Date/Time Prepared: 11/28/2017 9:19 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	460,118,597	1.00
2.00	Less contractual allowances and discounts on patients' accounts	284,924,533	2.00
3.00	Net patient revenues (line 1 minus line 2)	175,194,064	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	171,474,203	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,719,861	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	20,209,801	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,958,669	24.00
24.01	PENSION	0	24.01
24.02	UNREALIZED GAIN/LOSS	0	24.02
25.00	Total other income (sum of lines 6-24)	22,168,470	25.00
26.00	Total (line 5 plus line 25)	25,888,331	26.00
27.00	BAD DEBT	74,575	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	74,575	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,813,756	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0011	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/28/2017 9:19 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,260,261	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	54,669	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	51.41	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,314,930	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00