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: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/27/2018 2:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/27/2018 Time: 2:25 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 1/27/2018 Time: 2:25 pm
BMWBeLmjNJ8depm9dnkM5bjqrcLHEO
k:Uj:O9SMK:iiNNwbd.VQarGoY9IcG
OmsL1ZauZr0tV41K
PI: Date: 1/27/2018 Time: 2:25 pm
b..PAluoqLmBb0eRx:KIaFj1GabGa0
HM:zJ0x2Pvcppp4589zZ1sHdqUDpuo
IsnW0OGK890VZVDt

(Signed) [signature]
Officer or Administrator of Provider(s)

CFO
Title

1/29/18
Date

		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	69,090	-175,385	0	1,274,339	1.00
2.00	Subprovider - IPF	0	17,771	-357		-189,830	2.00
3.00	Subprovider - IRF	0	-7,946	-105		117,663	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	78,915	-175,847	0	1,202,172	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.

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FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/27/2018 2:25 pm

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Provider use only

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10. NPR Date:
11. Contractor's Vendor Code: 4
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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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(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	69,090	-175,385	0	1,274,339	1.00
2.00	Subprovider - IPF	0	17,771	-357		-189,830	2.00
3.00	Subprovider - IRF	0	-7,946	-105		117,663	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	78,915	-175,847	0	1,202,172	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.
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3901 HOSPITAL LANE	PO Box:			1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47802	County: VIGO	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	TERRE HAUTE REGIONAL HOSPITAL	150046	45460	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	TERRE HAUTE PSYCHIATRIC UNIT	15S046	45460	4	09/01/1991	N	P	O	4.00
5.00	Subprovider - IRF	TERRE HAUTE REHAB UNIT	15T046	45460	5	09/01/2006	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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2016	08/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	676	255	35	188	2,819	65	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.	64	49	0	0	107		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	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	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

		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: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	337,543	0	830,696	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	44H070	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: HOSPITAL CORP. OF AMERICA	Contractor's Name: CAHABA	Contractor's Number: 10301	141.00
142.00	Street: ONE PARK PLAZA	PO Box:		142.00
143.00	City: NASHVILLE	State: TN	Zip Code: 37203	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	02/22/2017	146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/27/2018 2:15 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	03/30/2016	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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 1/27/2018 2:15 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	01/11/2018	Y	01/11/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/27/2018 2:15 pm

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAMES	WELLS	41.00
42.00	Enter the employer/company name of the cost report preparer.	HCA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-344-6359	JAMES.WELLS2@HCAHEALTHCARE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/27/2018 2:15 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2018 2:15 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	142	51,830	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)		142	51,830	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,570	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)		160	58,400	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		191				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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2018 2:15 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,342	1,154	16,561			1.00
2.00	HMO and other (see instructions)	1,663	2,819				2.00
3.00	HMO IPF Subprovider	123	0				3.00
4.00	HMO IRF Subprovider	57	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)	9,342	1,154	16,561			7.00
8.00	INTENSIVE CARE UNIT	1,542	0	3,184			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	578			13.00
14.00	Total (see instructions)	10,884	1,154	20,323	0.00	560.43	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,623	2,848	6,635	0.00	34.94	16.00
17.00	SUBPROVIDER - IRF	1,119	113	1,780	0.00	11.29	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	121			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	606.66	27.00
28.00	Observation Bed Days		919	2,704			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	65	85			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: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-3 Part I Date/Time Prepared: 1/27/2018 2:15 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,642	287	5,254	1.00
2.00	HMO and other (see instructions)			326	975		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				7		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	2,642	287	5,254	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	197	102	1,064	16.00
17.00	SUBPROVIDER - IRF	0.00	0	81	8	128	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 1/27/2018 2:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	36,622,481	0	36,622,481	1,261,848.00	29.02	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,646,981	0	3,646,981	125,783.00	28.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,300,550	0	2,300,550	37,619.00	61.15	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		337,004	0	337,004	1,898.00	177.56	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		6,458,899	0	6,458,899	169,530.00	38.10	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)		9,401,973	0	9,401,973			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,039,827	0	1,039,827			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		1,298,606	0	1,298,606			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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	89,697	0	89,697	2,669.00	33.61	26.00
27.00	Administrative & General	5.00	5,520,991	-152,850	5,368,141	137,628.00	39.00	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 1/27/2018 2:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		131,894	0	131,894	519.00	254.13	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	768,804	0	768,804	28,210.00	27.25	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	890,354	0	890,354	64,851.00	13.73	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	612,938	-177,846	435,092	33,564.00	12.96	34.00
35.00	Dietary under contract (see instructions)		279,322	0	279,322	7,428.00	37.60	35.00
36.00	Cafeteria	11.00	0	177,846	177,846	13,720.00	12.96	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	467,307	152,850	620,157	14,169.00	43.77	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	46,683	0	46,683	1,343.00	34.76	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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 1/27/2018 2:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		37,033,697	0	37,033,697	1,269,795.00	29.17	1.00
2.00	Excluded area salaries (see instructions)		3,646,981	0	3,646,981	125,783.00	28.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,386,716	0	33,386,716	1,144,012.00	29.18	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,096,453	0	9,096,453	209,047.00	43.51	4.00
5.00	Subtotal wage-related costs (see inst.)		10,700,579	0	10,700,579	0.00	32.05	5.00
6.00	Total (sum of lines 3 thru 5)		53,183,748	0	53,183,748	1,353,059.00	39.31	6.00
7.00	Total overhead cost (see instructions)		8,807,990	0	8,807,990	304,101.00	28.96	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 1/27/2018 2:15 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,259,564	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	90,725	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	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)	5,719,564	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	21,395	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,414	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)	457,774	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	51,765	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,238,971	17.00
18.00	Medicare Taxes - Employers Portion Only	523,869	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	-92,779	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	133,538	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,441,800	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 1/27/2018 2:15 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,348,661	10,441,800	1.00
2.00	Hospital	2,300,550	9,401,973	2.00
3.00	Subprovider - IPF	46,546	507,334	3.00
4.00	Subprovider - IRF	1,565	209,289	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	0	0	17.00
18.00	Other	0	323,204	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-10 | Date/Time Prepared: 1/27/2018 2:15 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.152796	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	17,108,345	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	157,435,588	6.00
7.00	Medicaid cost (line 1 times line 6)	24,055,528	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)	6,947,183	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)	6,947,183	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)	21,355,111	796,830	22,151,941	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,262,976	650,619	3,913,595	21.00
22.00	Payments received from patients for amounts previously written off as charity care	137,852	13,020	150,872	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,125,124	637,599	3,762,723	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?	Y	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	172,581	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,611,563	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	337,853	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	519,773	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	6,091,790	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,112,721	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,875,444	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,822,627	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,749,302	2,749,302	207,507	2,956,809	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,687,429	2,687,429	702,256	3,389,685	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89,697	7,666,938	7,756,635	123,202	7,879,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,520,991	11,702,707	17,223,698	-386,299	16,837,399	5.00
7.00	00700	OPERATION OF PLANT	768,804	2,909,983	3,678,787	-4,351	3,674,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	528,232	528,232	0	528,232	8.00
9.00	00900	HOUSEKEEPING	890,354	407,667	1,298,021	-15,511	1,282,510	9.00
10.00	01000	DIETARY	612,938	1,171,453	1,784,391	-520,562	1,263,829	10.00
11.00	01100	CAFETERIA	0	0	0	516,596	516,596	11.00
13.00	01300	NURSING ADMINISTRATION	467,307	104,369	571,676	147,545	719,221	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,683	997,593	1,044,276	-2,899	1,041,377	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,491,147	3,423,193	8,914,340	10,136	8,924,476	30.00
31.00	03100	INTENSIVE CARE UNIT	1,985,050	588,998	2,574,048	-6,430	2,567,618	31.00
40.00	04000	SUBPROVIDER - IPF	1,779,372	1,120,876	2,900,248	-2,623	2,897,625	40.00
41.00	04100	SUBPROVIDER - IRF	734,038	130,259	864,297	-2,322	861,975	41.00
43.00	04300	NURSERY	146,228	68,160	214,388	0	214,388	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,465,246	4,714,792	8,180,038	-44,363	8,135,675	50.00
51.00	05100	RECOVERY ROOM	478,004	99,317	577,321	-8	577,313	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	839,062	407,029	1,246,091	-7,679	1,238,412	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	967,554	1,953,387	2,920,941	-195,882	2,725,059	54.00
54.01	03630	ULTRA SOUND	173,782	34,334	208,116	0	208,116	54.01
54.02	03440	MAMMOGRAPHY	131,602	103,841	235,443	-1,087	234,356	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	599,157	464,659	1,063,816	-27,802	1,036,014	55.00
56.00	05600	RADIOISOTOPE	183,444	667,305	850,749	-607	850,142	56.00
57.00	05700	CT SCAN	510,039	224,462	734,501	-90	734,411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	226,237	101,659	327,896	0	327,896	58.00
59.00	05900	CARDIAC CATHETERIZATION	534,976	-2,106	532,870	-472	532,398	59.00
60.00	06000	LABORATORY	1,185,857	1,606,712	2,792,569	-107,823	2,684,746	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	18,203	658,595	676,798	0	676,798	62.00
65.00	06500	RESPIRATORY THERAPY	1,056,996	554,476	1,611,472	-179,692	1,431,780	65.00
66.00	06600	PHYSICAL THERAPY	1,093,137	202,545	1,295,682	-1,697	1,293,985	66.00
69.00	06900	ELECTROCARDIOLOGY	500,513	292,783	793,296	-35,513	757,783	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,139	11,661	58,800	-3,086	55,714	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	380,609	5,920,334	6,300,943	-51,614	6,249,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,131,975	7,131,975	174,329	7,306,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,443,785	8,947,674	10,391,459	-14,087	10,377,372	73.00
74.00	07400	RENAL DIALYSIS	179	672,958	673,137	0	673,137	74.00
76.00	03950	LITHOTRIPSY	0	231,462	231,462	0	231,462	76.00
76.01	03330	ENDOSCOPY	511,579	597,057	1,108,636	-144,283	964,353	76.01
76.02	03040	PRISION CLINIC	133,388	18,243	151,631	-1,362	150,269	76.02
76.03	03050	WOUND CARE	65,003	661,756	726,759	-1,472	725,287	76.03
76.04	03060	OPIC	427,625	178,979	606,604	-1,463	605,141	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,983,185	8,672,143	10,655,328	-118,907	10,536,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,488,910	81,385,191	116,874,101	1,585	116,875,686	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,475	13,818	37,293	0	37,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	861,071	208,424	1,069,495	-1,585	1,067,910	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	249,025	21,299	270,324	0	270,324	194.02
200.00		TOTAL (SUM OF LINES 118-199)	36,622,481	81,628,732	118,251,213	0	118,251,213	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,592	3,054,401	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-33,063	3,356,622	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	357,884	8,237,721	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,063,686	22,901,085	5.00
7.00	00700	OPERATION OF PLANT	49,740	3,724,176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	528,232	8.00
9.00	00900	HOUSEKEEPING	43,798	1,326,308	9.00
10.00	01000	DIETARY	0	1,263,829	10.00
11.00	01100	CAFETERIA	-314,820	201,776	11.00
13.00	01300	NURSING ADMINISTRATION	-2,180	717,041	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,379	1,078,756	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-1,418,847	7,505,629	30.00
31.00	03100	INTENSIVE CARE UNIT	-11,429	2,556,189	31.00
40.00	04000	SUBPROVIDER - IPF	-774,763	2,122,862	40.00
41.00	04100	SUBPROVIDER - IRF	-10,759	851,216	41.00
43.00	04300	NURSERY	0	214,388	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-3,769,238	4,366,437	50.00
51.00	05100	RECOVERY ROOM	-278	577,035	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-23,234	1,215,178	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,041,233	1,683,826	54.00
54.01	03630	ULTRA SOUND	0	208,116	54.01
54.02	03440	MAMMOGRAPHY	0	234,356	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,496	1,034,518	55.00
56.00	05600	RADIOISOTOPE	0	850,142	56.00
57.00	05700	CT SCAN	0	734,411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	327,896	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	532,398	59.00
60.00	06000	LABORATORY	-2,513	2,682,233	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	676,798	62.00
65.00	06500	RESPIRATORY THERAPY	-125,050	1,306,730	65.00
66.00	06600	PHYSICAL THERAPY	-24,224	1,269,761	66.00
69.00	06900	ELECTROCARDIOLOGY	-10,500	747,283	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	55,714	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,249,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,306,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5	10,377,367	73.00
74.00	07400	RENAL DIALYSIS	0	673,137	74.00
76.00	03950	LITHOTRIPSY	0	231,462	76.00
76.01	03330	ENDOSCOPY	-85,061	879,292	76.01
76.02	03040	PRISION CLINIC	0	150,269	76.02
76.03	03050	WOUND CARE	-11,596	713,691	76.03
76.04	03060	OPIC	-74,181	530,960	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-7,242,406	3,294,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,326,797	108,548,889	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	-288,368	779,542	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	-217	270,107	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,615,382	109,635,831	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		186,692	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		695,205	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	TOTALS		0	881,897	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		27,866	1.00
	TOTALS		0	27,866	
	C - EXECUTIVE COMP.				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		126,113	1.00
2.00	NURSING ADMINISTRATION	13.00	152,850	13,790	2.00
	TOTALS		152,850	139,903	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	177,846	338,750	1.00
	TOTALS		177,846	338,750	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	165,874	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	165,874	
	F - DRUG				
1.00	DRUGS CHARGED TO PATIENTS	73.00		6,354	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	6,354	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	223,545	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	223,545	
	H - ER BEDHOLD				
1.00	ADULTS & PEDIATRICS	30.00	59,194	45,969	1.00
2.00	INTENSIVE CARE UNIT	31.00	3,328	2,585	2.00
	TOTALS		62,522	48,554	
	I - LOST CHARGES				
1.00	OPERATING ROOM	50.00	0	1,877	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,877	
	J - EQUIPMENT PROPERTY TAX				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,051	1.00
	TOTALS		0	7,051	
	K - CARDIOLGY NURSE NAVIGATOR 824				
1.00	ADULTS & PEDIATRICS	30.00	26,832	4,092	1.00
	TOTALS		26,832	4,092	
500.00	Grand Total: Increases		420,050	1,845,763	500.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6

Date/Time Prepared: 1/27/2018 2:15 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,911	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	65,680	10		2.00
3.00	OPERATION OF PLANT	7.00	0	4,351	0		3.00
4.00	HOUSEKEEPING	9.00	0	15,511	0		4.00
5.00	DIETARY	10.00	0	3,966	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	19,095	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,899	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	124,745	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	12,271	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	2,162	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	2,306	0		11.00
12.00	OPERATING ROOM	50.00	0	19,714	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,067	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	187,754	0		14.00
15.00	MAMMOGRAPHY	54.02	0	1,087	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,726	0		16.00
17.00	RADIOISOTOPE	56.00	0	607	0		17.00
18.00	LABORATORY	60.00	0	106,156	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	107,168	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	1,599	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	1,852	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,086	0		22.00
23.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	53,956	0		23.00
24.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,403	0		24.00
25.00	ENDOSCOPY	76.01	0	123,943	0		25.00
26.00	PRISION CLINIC	76.02	0	1,362	0		26.00
27.00	WOUND CARE	76.03	0	1,472	0		27.00
28.00	OPIC	76.04	0	1,463	0		28.00
29.00	OCCUPATIONAL MEDICINE	194.00	0	1,585	0		29.00
	TOTALS		0	881,897			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,866	12		1.00
	TOTALS		0	27,866			
	C - EXECUTIVE COMP.						
1.00	ADMINISTRATIVE & GENERAL	5.00	152,850	139,903	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		152,850	139,903			
	D - CAFETERIA						
1.00	DIETARY	10.00	177,846	338,750	0		1.00
	TOTALS		177,846	338,750			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	1,029	0		1.00
2.00	OPERATING ROOM	50.00	0	18,188	0		2.00
3.00	RECOVERY ROOM	51.00	0	8	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	228	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,008	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	472	0		6.00
7.00	LABORATORY	60.00	0	1,667	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	72,524	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	2,737	0		9.00
10.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	49,216	0		10.00
11.00	ENDOSCOPY	76.01	0	1,398	0		11.00
12.00	EMERGENCY	91.00	0	7,807	0		12.00
13.00	CT SCAN	57.00	0	90	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,502	0		14.00
	TOTALS		0	165,874			
	F - DRUG						
1.00	ADULTS & PEDIATRICS	30.00	0	146	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	24	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,092	0		3.00
4.00	ENDOSCOPY	76.01	0	4,415	0		4.00
5.00	EMERGENCY	91.00	0	24	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	72	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	461	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	16	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	104	0		9.00
	TOTALS		0	6,354			

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/27/2018 2:15 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	G - IMPLANTABLE DEVICES					
1.00	OPERATING ROOM	50.00	0	8,338	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	360	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16	0	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	23,076	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	98	0	5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	160,594	0	6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,536	0	7.00
8.00	ENDOSCOPY	76.01	0	14,527	0	8.00
	TOTALS		0	223,545		
	H - ER BEDHOLD					
1.00	EMERGENCY	91.00	62,522	48,554	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		62,522	48,554		
	I - LOST CHARGES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,846	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	31	0	2.00
	TOTALS		0	1,877		
	J - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,051	13	1.00
	TOTALS		0	7,051		
	K - CARDIOLGY NURSE NAVIGATOR 824					
1.00	ELECTROCARDIOLOGY	69.00	26,832	4,092	0	1.00
	TOTALS		26,832	4,092		
500.00	Grand Total: Decreases		420,050	1,845,763		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 1/27/2018 2:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,262,718	0	0	0	0	1.00
2.00	Land Improvements	3,158,371	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	0	0	0	3.00
4.00	Building Improvements	7,764,969	291,125	0	291,125	0	4.00
5.00	Fixed Equipment	27,059,404	19,666	0	19,666	0	5.00
6.00	Movable Equipment	43,431,502	3,790,330	0	3,790,330	864,978	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,315,179	4,101,121	0	4,101,121	864,978	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	121,315,179	4,101,121	0	4,101,121	864,978	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,262,718	0	1.00
2.00	Land Improvements	3,158,371	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	3.00
4.00	Building Improvements	8,056,094	0	4.00
5.00	Fixed Equipment	27,079,070	0	5.00
6.00	Movable Equipment	46,356,854	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	124,551,322	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	124,551,322	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 1/27/2018 2:15 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,373,121	0	0	0	376,181	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,498,596	173,578	15,255	0	0	2.00
3.00	Total (sum of lines 1-2)	4,871,717	173,578	15,255	0	376,181	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,749,302	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,687,429	2.00
3.00	Total (sum of lines 1-2)	0	5,436,731	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part III | Date/Time Prepared: 1/27/2018 2:15 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	78,194,468	0	78,194,468	0.627809	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,356,854	0	46,356,854	0.372191	0	2.00
3.00	Total (sum of lines 1-2)	124,551,322	0	124,551,322	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,470,713	186,692	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,465,533	868,783	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,936,246	1,055,475	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	27,866	369,130	0	3,054,401	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,255	0	7,051	0	3,356,622	2.00
3.00	Total (sum of lines 1-2)	15,255	27,866	376,181	0	6,411,023	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/27/2018 2:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-11,009,095			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	7,021,515			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	X-RAY COPY	B	-2,783	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01	CAFETERIA	B	-294,992	CAFETERIA	11.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/27/2018 2:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	VENDING	B	-19,828	CAFETERIA	11.00	0	33.02
33.03	MEDICAL RECORDS	B	-1,662	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	ED OTHER	B	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	INTEREST INCOME	B	-14,855	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HOSPICE	B	-97,016	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	UNCLAIMED PROPERTY	B	-4,587	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	WORKER'S COMP. PAID CLAIMS	A	-68,648	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	WORKER'S COMP INSURANCE	A	-42,300	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	PATIENT ACCOUNT INTEREST	A	-58	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PATIENT TELEPHONES	A	-9,937	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PATIENT TELEPHONES	A	-48,029	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PATIENT TV'S	A	-40,320	OPERATION OF PLANT	7.00	0	33.13
33.14	CONSULTING 900-317	A	-40,150	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ADMIN. TRAVEL 900-750	A	-3,630	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	ADMIN. MEALS 900-764	A	-7,737	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	ADMIN. PARTIES & BANQUETS 900-760	A	-920	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	MISC. XXX870	A	-4,759	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	NONPATIENT GIFTS	A	-23,150	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	NONPATIENT GIFTS	A	-435	HOUSEKEEPING	9.00	0	33.20
33.21	NONPATIENT GIFTS	A	-45	EMERGENCY	91.00	0	33.21
33.22	SPOUSE TRAVEL	A	-57	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	ALCOHOL	A	-766	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	ALCOHOL	A	-5,814	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	ALCOHOL	A	-87	ADULTS & PEDIATRICS	30.00	0	33.25
33.26	ALCOHOL	A	-10	INTENSIVE CARE UNIT	31.00	0	33.26
33.27	ALCOHOL	A	-19	ENDOSCOPY	76.01	0	33.27
33.28	ALCOHOL	A	-42	EMERGENCY	91.00	0	33.28
33.29	COUNTRY CLUB DUES	A	-3,278	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	PHYSICIAN RECRUITMENT	A	-295	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	PHYSICIAN RECRUITMENT	A	-5,155	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	PHYSICIAN RECRUITMENT	A	-7,579	SUBPROVIDER - IRF	41.00	0	33.32
33.33	NONALLOWABLES 900805	A	-12,208	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	CONTRIBUTIONS	A	-25,649	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	MED STAFF NONALLOWABLES 843971	A	-85,769	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	POB DEPT. 858	A	-2,644	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	PUBLIC RELATIONS DEPT. 920	A	-59,912	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	SALES DEPT. 965	A	-6,776	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	LEGAL FEES	A	-13,321	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	CLINICAL RESEARCH	A	-1,226	RADIOLOGY-THERAPEUTIC	55.00	0	33.40
33.41	CLINICAL RESEARCH	A	-204	OPIC	76.04	0	33.41
33.42	CLINICAL RESEARCH	A	-261	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.42
33.43	DEPRECIATION BUILDING	A	-2,035	CAP REL COSTS-BLDG & FIXT	1.00	9	33.43
33.44	DEPRECIATION MME	A	-33,063	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.44
33.45	CRNA	A	-3,019,425	OPERATING ROOM	50.00	0	33.45
33.46	NURSE PRACTITIONER	A	-286,368	OCCUPATIONAL MEDICINE	194.00	0	33.46
33.47	NURSE PRACTITIONER	A	-8,955	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	NURSE PRACTITIONER	A	-1,297	ADULTS & PEDIATRICS	30.00	0	33.48
33.49	LOBBYING DUES	A	-11,173	ADMINISTRATIVE & GENERAL	5.00	0	33.49
33.50	MOB ACCOUNTING	A	-1,337	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	MOB ACCOUNTING	A	-371	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.51
33.52	USEFUL LIFE ADJUSTMENT	A	-44,512	CAP REL COSTS-BLDG & FIXT	1.00	9	33.52
33.53	PHYSICIAN RECORDS STORAGE	A	-25	OPERATION OF PLANT	7.00	0	33.53
33.54	ADVERTISING	A	-4,079	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55	ADVERTISING	A	-3,020	SUBPROVIDER - IRF	41.00	0	33.55
33.56	ADVERTISING	A	-546	ENDOSCOPY	76.01	0	33.56
33.57	ADVERTISING	A	-234,396	EMERGENCY	91.00	0	33.57
33.58	ADVERTISING	A	-2,000	OCCUPATIONAL MEDICINE	194.00	0	33.58
33.59	PATIENT TV'S	A	-4,250	ADULTS & PEDIATRICS	30.00	0	33.59
33.60	PATIENT TV'S	A	-425	INTENSIVE CARE UNIT	31.00	0	33.60
33.61	PATIENT TV'S	A	-425	DELIVERY ROOM & LABOR ROOM	52.00	0	33.61
33.62	PATIENT TV'S	A	-1,605	RADIOLOGY-DIAGNOSTIC	54.00	0	33.62
33.63	OTHER REVENUE	B	-6,047	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	OTHER REVENUE	B	-17	HOUSEKEEPING	9.00	0	33.64
33.65	PATHOLOGY SLIDES	B	-2,513	LABORATORY	60.00	0	33.65
33.66	OTHER REVENUE	B	-5	DRUGS CHARGED TO PATIENTS	73.00	0	33.66
33.67			0		0.00	0	33.67
33.68			0		0.00	0	33.68
33.69			0		0.00	0	33.69

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 Date/Time Prepared: 1/27/2018 2:15 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.70			0		0.00	0	33.70
33.71			0		0.00	0	33.71
33.72			0		0.00	0	33.72
33.73			0		0.00	0	33.73
33.74			0		0.00	0	33.74
33.75			0		0.00	0	33.75
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,615,382				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 1/27/2018 2:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HPG	94,984	211,467	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT&S	1,833,839	1,758,415	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	2,129,686	7,016,524	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	311,822	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SSC	2,556,551	2,556,551	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1,331,165	1,331,165	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	52,804	59,187	4.03
4.04	13.00	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS	19,280	21,460	4.04
4.05	30.00	ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	1,000,778	1,113,956	4.05
4.06	31.00	INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	97,208	108,202	4.06
4.07	40.00	SUBPROVIDER - IPF	PARALLON WORKFORCE SOLUTIONS	41,817	46,546	4.07
4.08	41.00	SUBPROVIDER - IRF	PARALLON WORKFORCE SOLUTIONS	1,406	1,566	4.08
4.09	50.00	OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	44,769	49,832	4.09
4.10	51.00	RECOVERY ROOM	PARALLON WORKFORCE SOLUTIONS	2,457	2,735	4.10
4.11	52.00	DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	201,693	224,502	4.11
4.12	66.00	PHYSICAL THERAPY	PARALLON WORKFORCE SOLUTIONS	22,983	25,582	4.12
4.13	91.00	EMERGENCY	PARALLON WORKFORCE SOLUTIONS	643,583	716,366	4.13
4.14	194.02	SITTERS	PARALLON WORKFORCE SOLUTIONS	1,916	2,133	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	743,472	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	34,425	34,425	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	1,230,170	1,253,040	4.17
4.18	16.00	MEDICAL RECORDS & LIBRARY	HIM	1,000,020	962,339	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	138,838	138,838	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	CREDENTIALING	70,323	70,323	4.20
4.21	40.00	SUBPROVIDER - IPF	BEHAVIORAL HEALTH	107,615	115,822	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	IT&S PARALLON	329,626	329,626	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY	PREBILL DENIAL	29,416	28,056	4.23
4.24	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	534,849	534,849	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	CAD STORAGE	25,964	25,899	4.25
4.26	5.00	ADMINISTRATIVE & GENERAL	CALL CENTER	0	73,930	4.26
4.27	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	0	89,245	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	524,169	863,070	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE	0	10,721	4.29
4.30	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	154,895	4.30
4.31	5.00	ADMINISTRATIVE & GENERAL	MARKETING ALLOCATIONS	0	137,614	4.31
4.32	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	154,003	157,841	4.32
4.33	4.00	EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP.	0	2,292	4.33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INS_POOLING ADJ.	0	-482,459	4.34
4.35	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-12,060,824	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	569,764	0	4.36
4.37	1.00	CAP REL COSTS-BLDG & FIXT	POB SPACE	71,797	0	4.37
4.38	5.00	ADMINISTRATIVE & GENERAL	POB SPACE	32,882	0	4.38
4.39	7.00	OPERATION OF PLANT	POB SPACE	61,443	0	4.39
4.40	9.00	HOUSEKEEPING	POB SPACE	31,751	0	4.40
4.41	1.00	CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	72,342	0	4.41
4.42	5.00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	1,439	0	4.42
4.43	7.00	OPERATION OF PLANT	PAVILLION SPACE	28,642	0	4.43
4.44	9.00	HOUSEKEEPING	PAVILLION SPACE	12,499	0	4.44
4.45	0.00			0	0	4.45
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,450,718	8,429,203	5.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-1 Date/Time Prepared: 1/27/2018 2:15 pm

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		100.00	PARALLON	100.00	6.00
7.00	B		52.73	HPG	52.73	7.00
8.00	B		100.00	HCI	100.00	8.00
9.00	B		100.00	CAPITAL DIVISIO	100.00	9.00
10.00	B		100.00	WORKFORCE MGT.	100.00	10.00
10.01	B		100.00	HCA	100.00	10.01
10.02	B		100.00	POB	100.00	10.02
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 1/27/2018 2:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-116,483	0	1.00
2.00	75,424	0	2.00
3.00	-4,886,838	0	3.00
4.00	311,822	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	-6,383	0	4.03
4.04	-2,180	0	4.04
4.05	-113,178	0	4.05
4.06	-10,994	0	4.06
4.07	-4,729	0	4.07
4.08	-160	0	4.08
4.09	-5,063	0	4.09
4.10	-278	0	4.10
4.11	-22,809	0	4.11
4.12	-2,599	0	4.12
4.13	-72,783	0	4.13
4.14	-217	0	4.14
4.15	-743,472	0	4.15
4.16	0	0	4.16
4.17	-22,870	0	4.17
4.18	37,681	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	-8,207	0	4.21
4.22	0	0	4.22
4.23	1,360	0	4.23
4.24	0	0	4.24
4.25	65	0	4.25
4.26	-73,930	0	4.26
4.27	-89,245	0	4.27
4.28	-338,901	0	4.28
4.29	-10,721	0	4.29
4.30	-154,895	0	4.30
4.31	-137,614	0	4.31
4.32	-3,838	0	4.32
4.33	-2,292	0	4.33
4.34	482,459	0	4.34
4.35	12,060,824	0	4.35
4.36	569,764	0	4.36
4.37	71,797	9	4.37
4.38	32,882	0	4.38
4.39	61,443	0	4.39
4.40	31,751	0	4.40
4.41	72,342	9	4.41
4.42	1,439	0	4.42
4.43	28,642	0	4.43
4.44	12,499	0	4.44
4.45	0	0	4.45
5.00	7,021,515		5.00

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

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

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

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

6.00	MANAGEMENT	6.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet A-8-1 Date/Time Prepared: 1/27/2018 2:15 pm

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
7.00	PURCHASING	7.00
8.00	INSURANCE	8.00
9.00	MANAGEMENT	9.00
10.00	STAFFING	10.00
10.01	HOSPITAL MGT.	10.01
10.02	PROFESSIONAL BU	10.02
100.00		100.00

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

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

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,203,019	1,203,019	0	211,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	761,827	761,827	0	181,300	0	2.00
3.00	50.00	OPERATING ROOM	766,073	741,233	24,840	246,400	180	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,036,845	1,036,845	0	271,900	0	4.00
5.00	55.00	RADIOLOGY-THERAPEUTIC	270	270	0	271,900	0	5.00
6.00	65.00	RESPIRATORY THERAPY	125,050	125,050	0	211,500	0	6.00
7.00	66.00	PHYSICAL THERAPY	72,975	-2,738	75,713	211,500	505	7.00
8.00	69.00	ELECTROCARDIOLOGY	10,500	10,500	0	211,500	0	8.00
9.00	76.01	ENDOSCOPY	103,450	71,450	32,000	246,400	160	9.00
10.00	76.03	WOUND CARE	36,000	0	36,000	211,500	240	10.00
11.00	76.04	OPIC	122,073	33,622	88,451	211,500	473	11.00
12.00	91.00	EMERGENCY	6,969,712	6,889,712	80,000	211,500	340	12.00
200.00			11,207,794	10,870,790	337,004		1,898	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	21,323	1,066	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	51,350	2,568	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	76.01	ENDOSCOPY	18,954	948	0	0	0	9.00
10.00	76.03	WOUND CARE	24,404	1,220	0	0	0	10.00
11.00	76.04	OPIC	48,096	2,405	0	0	0	11.00
12.00	91.00	EMERGENCY	34,572	1,729	0	0	0	12.00
200.00			198,699	9,936	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,203,019		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	761,827		2.00
3.00	50.00	OPERATING ROOM	0	21,323	3,517	744,750		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,036,845		4.00
5.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	270		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	125,050		6.00
7.00	66.00	PHYSICAL THERAPY	0	51,350	24,363	21,625		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	10,500		8.00
9.00	76.01	ENDOSCOPY	0	18,954	13,046	84,496		9.00
10.00	76.03	WOUND CARE	0	24,404	11,596	11,596		10.00
11.00	76.04	OPIC	0	48,096	40,355	73,977		11.00
12.00	91.00	EMERGENCY	0	34,572	45,428	6,935,140		12.00
200.00			0	198,699	138,305	11,009,095		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,054,401	3,054,401				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,356,622		3,356,622			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,237,721	31,615	35,032	8,304,368		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,901,085	249,736	276,726	1,220,248	24,647,795	5.00
7.00	00700	OPERATION OF PLANT	3,724,176	704,583	780,731	174,759	5,384,249	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	528,232	29,853	33,080	0	591,165	8.00
9.00	00900	HOUSEKEEPING	1,326,308	10,741	11,902	202,389	1,551,340	9.00
10.00	01000	DIETARY	1,263,829	48,763	54,034	98,902	1,465,528	10.00
11.00	01100	CAFETERIA	201,776	31,101	34,462	40,427	307,766	11.00
13.00	01300	NURSING ADMINISTRATION	717,041	8,346	9,248	140,970	875,605	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,078,756	48,064	53,258	10,612	1,190,690	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,505,629	526,601	583,514	1,267,753	9,883,497	30.00
31.00	03100	INTENSIVE CARE UNIT	2,556,189	89,610	99,295	451,984	3,197,078	31.00
40.00	04000	SUBPROVIDER - IPF	2,122,862	80,901	89,645	404,474	2,697,882	40.00
41.00	04100	SUBPROVIDER - IRF	851,216	96,178	106,572	166,856	1,220,822	41.00
43.00	04300	NURSERY	214,388	8,802	9,753	33,240	266,183	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,366,437	212,649	235,631	787,695	5,602,412	50.00
51.00	05100	RECOVERY ROOM	577,035	13,278	14,714	108,657	713,684	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,215,178	60,550	67,094	190,730	1,533,552	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,683,826	110,173	122,080	219,938	2,136,017	54.00
54.01	03630	ULTRA SOUND	208,116	3,423	3,793	39,503	254,835	54.01
54.02	03440	MAMMOGRAPHY	234,356	12,604	13,966	29,915	290,841	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,034,518	52,077	57,705	136,196	1,280,496	55.00
56.00	05600	RADIOISOTOPE	850,142	6,256	6,932	41,699	905,029	56.00
57.00	05700	CT SCAN	734,411	13,506	14,966	115,938	878,821	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,896	8,768	9,716	51,427	397,807	58.00
59.00	05900	CARDIAC CATHETERIZATION	532,398	19,332	21,421	121,607	694,758	59.00
60.00	06000	LABORATORY	2,682,233	45,121	49,998	269,561	3,046,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	676,798	2,698	2,989	4,138	686,623	62.00
65.00	06500	RESPIRATORY THERAPY	1,306,730	13,818	15,311	240,269	1,576,128	65.00
66.00	06600	PHYSICAL THERAPY	1,269,761	114,532	126,910	248,484	1,759,687	66.00
69.00	06900	ELECTROCARDIOLOGY	747,283	18,480	20,477	107,674	893,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,714	9,190	10,183	10,715	85,802	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,249,329	71,585	79,322	86,517	6,486,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,306,304	0	0	0	7,306,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,377,367	22,637	25,083	328,191	10,753,278	73.00
74.00	07400	RENAL DIALYSIS	673,137	3,979	4,409	41	681,566	74.00
76.00	03950	LITHOTRIPSY	231,462	0	0	0	231,462	76.00
76.01	03330	ENDOSCOPY	879,292	16,229	17,983	116,289	1,029,793	76.01
76.02	03040	PRISION CLINIC	150,269	63,231	70,064	30,321	313,885	76.02
76.03	03050	WOUND CARE	713,691	14,568	16,143	14,776	759,178	76.03
76.04	03060	OPIC	530,960	32,248	35,733	97,205	696,146	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,294,015	86,677	96,044	436,592	3,913,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,548,889	2,992,503	3,315,919	8,046,692	108,188,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,293	5,117	5,671	5,336	53,417	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	779,542	31,615	35,032	195,733	1,041,922	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	25,166	0	0	25,166	194.01
194.02	07952	SITTERS	270,107	0	0	56,607	326,714	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	109,635,831	3,054,401	3,356,622	8,304,368	109,635,831	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,647,795					5.00
7.00	00700	OPERATION OF PLANT	1,561,513	6,945,762				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	171,447	100,245	862,857			8.00
9.00	00900	HOUSEKEEPING	449,912	36,067	0	2,037,319		9.00
10.00	01000	DIETARY	425,025	163,744	0	49,606	2,103,903	10.00
11.00	01100	CAFETERIA	89,257	104,435	0	31,639	0	11.00
13.00	01300	NURSING ADMINISTRATION	253,939	28,027	0	8,491	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,318	161,394	0	48,894	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,866,362	1,768,292	499,845	535,700	820,524	30.00
31.00	03100	INTENSIVE CARE UNIT	927,201	300,905	94,919	91,159	61,441	31.00
40.00	04000	SUBPROVIDER - IPF	782,426	271,661	197,798	82,300	280,448	40.00
41.00	04100	SUBPROVIDER - IRF	354,057	322,959	53,064	97,840	103,991	41.00
43.00	04300	NURSERY	77,197	29,555	17,231	8,954	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,624,784	714,059	0	216,324	0	50.00
51.00	05100	RECOVERY ROOM	206,979	44,588	0	13,508	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,753	203,321	0	61,596	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,477	369,953	0	112,077	0	54.00
54.01	03630	ULTRA SOUND	73,906	11,494	0	3,482	0	54.01
54.02	03440	MAMMOGRAPHY	84,348	42,323	0	12,822	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	371,363	174,870	0	52,977	0	55.00
56.00	05600	RADIOISOTOPE	262,472	21,006	0	6,364	0	56.00
57.00	05700	CT SCAN	254,871	45,352	0	13,739	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	115,370	29,442	0	8,920	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	201,490	64,914	0	19,666	0	59.00
60.00	06000	LABORATORY	883,650	151,514	0	45,901	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	199,131	9,059	0	2,744	0	62.00
65.00	06500	RESPIRATORY THERAPY	457,101	46,400	0	14,057	0	65.00
66.00	06600	PHYSICAL THERAPY	510,336	384,589	0	116,511	0	66.00
69.00	06900	ELECTROCARDIOLOGY	259,248	62,055	0	18,800	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,884	30,858	0	9,348	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,881,256	240,379	0	72,823	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,118,938	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,118,601	76,012	0	23,028	0	73.00
74.00	07400	RENAL DIALYSIS	197,664	13,362	0	4,048	0	74.00
76.00	03950	LITHOTRIPSY	67,127	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	298,655	54,496	0	16,510	0	76.01
76.02	03040	PRISION CLINIC	91,031	212,324	0	64,323	0	76.02
76.03	03050	WOUND CARE	220,173	48,919	0	14,820	0	76.03
76.04	03060	OPIC	201,893	108,285	0	32,805	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,134,924	291,053	0	88,175	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,228,079	6,737,911	862,857	1,999,951	1,266,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,492	17,184	0	5,206	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	302,173	106,162	0	32,162	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	7,299	84,505	0	0	837,499	194.01
194.02	07952	SITTERS	94,752	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,647,795	6,945,762	862,857	2,037,319	2,103,903	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	533,097					11.00
13.00	01300	NURSING ADMINISTRATION	11,443	1,177,505				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	861	0	1,747,157			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	102,905	468,324	56,861	17,002,310	0	30.00
31.00	03100	INTENSIVE CARE UNIT	36,688	162,110	22,941	4,894,442	0	31.00
40.00	04000	SUBPROVIDER - IPF	32,831	85,402	63,049	4,493,797	0	40.00
41.00	04100	SUBPROVIDER - IRF	13,544	52,466	5,782	2,224,525	0	41.00
43.00	04300	NURSERY	2,698	11,440	2,152	415,410	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,937	159,408	224,345	8,605,269	0	50.00
51.00	05100	RECOVERY ROOM	8,820	39,467	31,847	1,058,893	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,482	71,768	8,739	2,339,211	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,852	0	37,763	3,293,139	0	54.00
54.01	03630	ULTRA SOUND	3,206	0	11,587	358,510	0	54.01
54.02	03440	MAMMOGRAPHY	2,428	0	5,620	438,382	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	11,055	0	42,604	1,933,365	0	55.00
56.00	05600	RADIOISOTOPE	3,385	0	32,462	1,230,718	0	56.00
57.00	05700	CT SCAN	9,411	0	137,624	1,339,818	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,174	0	33,951	589,664	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,871	19,045	67,243	1,076,987	0	59.00
60.00	06000	LABORATORY	21,880	0	166,642	4,316,500	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	336	0	16,618	914,511	0	62.00
65.00	06500	RESPIRATORY THERAPY	19,503	1,676	45,292	2,160,157	0	65.00
66.00	06600	PHYSICAL THERAPY	20,169	26	17,524	2,808,842	0	66.00
69.00	06900	ELECTROCARDIOLOGY	8,740	13,460	45,004	1,301,221	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	870	0	3,595	155,357	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,023	5,745	103,260	8,797,239	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	55,222	9,480,464	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,639	0	266,936	14,264,494	0	73.00
74.00	07400	RENAL DIALYSIS	3	0	12,835	909,478	0	74.00
76.00	03950	LITHOTRIPSY	0	0	7,321	305,910	0	76.00
76.01	03330	ENDOSCOPY	9,439	33,317	49,573	1,491,783	0	76.01
76.02	03040	PRISION CLINIC	2,461	367	1,073	685,464	0	76.02
76.03	03050	WOUND CARE	1,199	29,931	9,454	1,083,674	0	76.03
76.04	03060	OPIC	7,890	20,653	13,940	1,081,612	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	35,438	0	148,298	5,611,216	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	512,181	1,174,605	1,747,157	106,662,362	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	433	0	0	91,732	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	15,888	0	0	1,498,307	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	954,469	0	194.01
194.02	07952	SITTERS	4,595	2,900	0	428,961	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	533,097	1,177,505	1,747,157	109,635,831	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	17,002,310	30.00
31.00	03100	INTENSIVE CARE UNIT	4,894,442	31.00
40.00	04000	SUBPROVIDER - IPF	4,493,797	40.00
41.00	04100	SUBPROVIDER - IRF	2,224,525	41.00
43.00	04300	NURSERY	415,410	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	8,605,269	50.00
51.00	05100	RECOVERY ROOM	1,058,893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,339,211	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,293,139	54.00
54.01	03630	ULTRA SOUND	358,510	54.01
54.02	03440	MAMMOGRAPHY	438,382	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,933,365	55.00
56.00	05600	RADIOISOTOPE	1,230,718	56.00
57.00	05700	CT SCAN	1,339,818	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,076,987	59.00
60.00	06000	LABORATORY	4,316,500	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	914,511	62.00
65.00	06500	RESPIRATORY THERAPY	2,160,157	65.00
66.00	06600	PHYSICAL THERAPY	2,808,842	66.00
69.00	06900	ELECTROCARDIOLOGY	1,301,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,797,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,480,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,264,494	73.00
74.00	07400	RENAL DIALYSIS	909,478	74.00
76.00	03950	LITHOTRIPSY	305,910	76.00
76.01	03330	ENDOSCOPY	1,491,783	76.01
76.02	03040	PRISION CLINIC	685,464	76.02
76.03	03050	WOUND CARE	1,083,674	76.03
76.04	03060	OPIC	1,081,612	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	5,611,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,662,362	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	91,732	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	1,498,307	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	954,469	194.01
194.02	07952	SITTERS	428,961	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	109,635,831	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	31,615	35,032	66,647	66,647	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,161,145	249,736	276,726	2,687,607	9,791	5.00
7.00	00700	OPERATION OF PLANT	0	704,583	780,731	1,485,314	1,402	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,853	33,080	62,933	0	8.00
9.00	00900	HOUSEKEEPING	0	10,741	11,902	22,643	1,624	9.00
10.00	01000	DIETARY	0	48,763	54,034	102,797	794	10.00
11.00	01100	CAFETERIA	0	31,101	34,462	65,563	324	11.00
13.00	01300	NURSING ADMINISTRATION	98	8,346	9,248	17,692	1,131	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,629	48,064	53,258	111,951	85	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,104	526,601	583,514	1,115,219	10,184	30.00
31.00	03100	INTENSIVE CARE UNIT	496	89,610	99,295	189,401	3,627	31.00
40.00	04000	SUBPROVIDER - IPF	213	80,901	89,645	170,759	3,246	40.00
41.00	04100	SUBPROVIDER - IRF	7	96,178	106,572	202,757	1,339	41.00
43.00	04300	NURSERY	0	8,802	9,753	18,555	267	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	228	212,649	235,631	448,508	6,321	50.00
51.00	05100	RECOVERY ROOM	13	13,278	14,714	28,005	872	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,029	60,550	67,094	128,673	1,530	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,173	122,080	232,253	1,765	54.00
54.01	03630	ULTRA SOUND	0	3,423	3,793	7,216	317	54.01
54.02	03440	MAMMOGRAPHY	0	12,604	13,966	26,570	240	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	52,077	57,705	109,782	1,093	55.00
56.00	05600	RADIOISOTOPE	0	6,256	6,932	13,188	335	56.00
57.00	05700	CT SCAN	0	13,506	14,966	28,472	930	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,768	9,716	18,484	413	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,332	21,421	40,753	976	59.00
60.00	06000	LABORATORY	0	45,121	49,998	95,119	2,163	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,698	2,989	5,687	33	62.00
65.00	06500	RESPIRATORY THERAPY	0	13,818	15,311	29,129	1,928	65.00
66.00	06600	PHYSICAL THERAPY	117	114,532	126,910	241,559	1,994	66.00
69.00	06900	ELECTROCARDIOLOGY	0	18,480	20,477	38,957	864	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,190	10,183	19,373	86	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71,585	79,322	150,907	694	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	22,637	25,083	47,720	2,633	73.00
74.00	07400	RENAL DIALYSIS	0	3,979	4,409	8,388	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	16,229	17,983	34,212	933	76.01
76.02	03040	PRISION CLINIC	0	63,231	70,064	133,295	243	76.02
76.03	03050	WOUND CARE	0	14,568	16,143	30,711	119	76.03
76.04	03060	OPIC	0	32,248	35,733	67,981	780	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,282	86,677	96,044	186,003	3,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,182,361	2,992,503	3,315,919	8,490,783	64,579	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,117	5,671	10,788	43	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	31,615	35,032	66,647	1,571	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	25,166	0	25,166	0	194.01
194.02	07952	SITTERS	10	0	0	10	454	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,182,371	3,054,401	3,356,622	8,593,394	66,647	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,697,398					5.00
7.00	00700	OPERATION OF PLANT	170,891	1,657,607				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,763	23,924	105,620			8.00
9.00	00900	HOUSEKEEPING	49,238	8,607	0	82,112		9.00
10.00	01000	DIETARY	46,514	39,078	0	1,999	191,182	10.00
11.00	01100	CAFETERIA	9,768	24,923	0	1,275	0	11.00
13.00	01300	NURSING ADMINISTRATION	27,791	6,689	0	342	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,791	38,517	0	1,971	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	313,692	422,004	61,185	21,592	74,561	30.00
31.00	03100	INTENSIVE CARE UNIT	101,472	71,811	11,619	3,674	5,583	31.00
40.00	04000	SUBPROVIDER - IPF	85,628	64,832	24,212	3,317	25,484	40.00
41.00	04100	SUBPROVIDER - IRF	38,748	77,074	6,495	3,943	9,450	41.00
43.00	04300	NURSERY	8,448	7,053	2,109	361	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	177,815	170,410	0	8,719	0	50.00
51.00	05100	RECOVERY ROOM	22,652	10,641	0	544	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,673	48,523	0	2,483	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,795	88,289	0	4,517	0	54.00
54.01	03630	ULTRA SOUND	8,088	2,743	0	140	0	54.01
54.02	03440	MAMMOGRAPHY	9,231	10,100	0	517	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	40,642	41,733	0	2,135	0	55.00
56.00	05600	RADIOISOTOPE	28,725	5,013	0	256	0	56.00
57.00	05700	CT SCAN	27,893	10,823	0	554	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,626	7,026	0	359	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,051	15,492	0	793	0	59.00
60.00	06000	LABORATORY	96,706	36,159	0	1,850	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	21,793	2,162	0	111	0	62.00
65.00	06500	RESPIRATORY THERAPY	50,025	11,073	0	567	0	65.00
66.00	06600	PHYSICAL THERAPY	55,851	91,782	0	4,696	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,372	14,809	0	758	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,723	7,364	0	377	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	205,883	57,366	0	2,935	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	231,895	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,260	18,140	0	928	0	73.00
74.00	07400	RENAL DIALYSIS	21,632	3,189	0	163	0	74.00
76.00	03950	LITHOTRIPSY	7,346	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	32,685	13,006	0	665	0	76.01
76.02	03040	PRISION CLINIC	9,962	50,671	0	2,592	0	76.02
76.03	03050	WOUND CARE	24,096	11,675	0	597	0	76.03
76.04	03060	OPIC	22,095	25,842	0	1,322	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	124,205	69,460	0	3,554	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,651,464	1,608,003	105,620	80,606	115,078	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,695	4,101	0	210	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	33,070	25,336	0	1,296	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	799	20,167	0	0	76,104	194.01
194.02	07952	SITTERS	10,370	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,697,398	1,657,607	105,620	82,112	191,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	101,853					11.00
13.00	01300	NURSING ADMINISTRATION	2,186	55,831				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165	0	190,480			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,667	22,205	6,202	2,066,511	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,009	7,687	2,502	404,385	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,272	4,050	6,877	394,677	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,587	2,488	631	345,512	0	41.00
43.00	04300	NURSERY	515	542	235	38,085	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,215	7,559	24,469	856,016	0	50.00
51.00	05100	RECOVERY ROOM	1,685	1,871	3,473	69,743	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,958	3,403	953	237,196	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,411	0	4,119	402,149	0	54.00
54.01	03630	ULTRA SOUND	613	0	1,264	20,381	0	54.01
54.02	03440	MAMMOGRAPHY	464	0	613	47,735	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,112	0	4,647	202,144	0	55.00
56.00	05600	RADIOISOTOPE	647	0	3,541	51,705	0	56.00
57.00	05700	CT SCAN	1,798	0	15,010	85,480	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	797	0	3,703	43,408	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,886	903	7,334	90,188	0	59.00
60.00	06000	LABORATORY	4,180	0	18,175	254,352	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	64	0	1,812	31,662	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,726	79	4,940	101,467	0	65.00
66.00	06600	PHYSICAL THERAPY	3,853	1	1,911	401,647	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,670	638	4,909	90,977	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166	0	392	30,481	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,342	272	11,263	430,662	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,023	237,918	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,089	0	29,034	444,804	0	73.00
74.00	07400	RENAL DIALYSIS	1	0	1,400	34,773	0	74.00
76.00	03950	LITHOTRIPSY	0	0	798	8,144	0	76.00
76.01	03330	ENDOSCOPY	1,803	1,580	5,407	90,291	0	76.01
76.02	03040	PRISION CLINIC	470	17	117	197,367	0	76.02
76.03	03050	WOUND CARE	229	1,419	1,031	69,877	0	76.03
76.04	03060	OPIC	1,507	979	1,520	122,026	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,770	0	16,175	409,670	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,857	55,693	190,480	8,311,433	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83	0	0	16,920	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,035	0	0	130,955	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	122,236	0	194.01
194.02	07952	SITTERS	878	138	0	11,850	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	101,853	55,831	190,480	8,593,394	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	2,066,511	30.00
31.00	03100	INTENSIVE CARE UNIT	404,385	31.00
40.00	04000	SUBPROVIDER - IPF	394,677	40.00
41.00	04100	SUBPROVIDER - IRF	345,512	41.00
43.00	04300	NURSERY	38,085	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	856,016	50.00
51.00	05100	RECOVERY ROOM	69,743	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,196	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402,149	54.00
54.01	03630	ULTRA SOUND	20,381	54.01
54.02	03440	MAMMOGRAPHY	47,735	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	202,144	55.00
56.00	05600	RADIOISOTOPE	51,705	56.00
57.00	05700	CT SCAN	85,480	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	90,188	59.00
60.00	06000	LABORATORY	254,352	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,662	62.00
65.00	06500	RESPIRATORY THERAPY	101,467	65.00
66.00	06600	PHYSICAL THERAPY	401,647	66.00
69.00	06900	ELECTROCARDIOLOGY	90,977	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,481	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	444,804	73.00
74.00	07400	RENAL DIALYSIS	34,773	74.00
76.00	03950	LITHOTRIPSY	8,144	76.00
76.01	03330	ENDOSCOPY	90,291	76.01
76.02	03040	PRISION CLINIC	197,367	76.02
76.03	03050	WOUND CARE	69,877	76.03
76.04	03060	OPIC	122,026	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	409,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,311,433	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,920	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	130,955	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	122,236	194.01
194.02	07952	SITTERS	11,850	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	8,593,394	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET 2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,293					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		359,308				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,750	3,750	36,532,784			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,622	29,622	5,368,141	-24,647,795	84,988,036	5.00
7.00	00700	OPERATION OF PLANT	83,573	83,573	768,804	0	5,384,249	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,541	3,541	0	0	591,165	8.00
9.00	00900	HOUSEKEEPING	1,274	1,274	890,354	0	1,551,340	9.00
10.00	01000	DIETARY	5,784	5,784	435,092	0	1,465,528	10.00
11.00	01100	CAFETERIA	3,689	3,689	177,846	0	307,766	11.00
13.00	01300	NURSING ADMINISTRATION	990	990	620,157	0	875,605	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,701	5,701	46,683	0	1,190,690	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,462	62,462	5,577,173	0	9,883,497	30.00
31.00	03100	INTENSIVE CARE UNIT	10,629	10,629	1,988,378	0	3,197,078	31.00
40.00	04000	SUBPROVIDER - IPF	9,596	9,596	1,779,372	0	2,697,882	40.00
41.00	04100	SUBPROVIDER - IRF	11,408	11,408	734,038	0	1,220,822	41.00
43.00	04300	NURSERY	1,044	1,044	146,228	0	266,183	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,223	25,223	3,465,246	0	5,602,412	50.00
51.00	05100	RECOVERY ROOM	1,575	1,575	478,004	0	713,684	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,182	7,182	839,062	0	1,533,552	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,068	13,068	967,554	0	2,136,017	54.00
54.01	03630	ULTRA SOUND	406	406	173,782	0	254,835	54.01
54.02	03440	MAMMOGRAPHY	1,495	1,495	131,602	0	290,841	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	6,177	6,177	599,157	0	1,280,496	55.00
56.00	05600	RADIOISOTOPE	742	742	183,444	0	905,029	56.00
57.00	05700	CT SCAN	1,602	1,602	510,039	0	878,821	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,040	1,040	226,237	0	397,807	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	2,293	534,976	0	694,758	59.00
60.00	06000	LABORATORY	5,352	5,352	1,185,857	0	3,046,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	320	320	18,203	0	686,623	62.00
65.00	06500	RESPIRATORY THERAPY	1,639	1,639	1,056,996	0	1,576,128	65.00
66.00	06600	PHYSICAL THERAPY	13,585	13,585	1,093,137	0	1,759,687	66.00
69.00	06900	ELECTROCARDIOLOGY	2,192	2,192	473,681	0	893,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,090	1,090	47,139	0	85,802	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,491	8,491	380,609	0	6,486,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,306,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,685	2,685	1,443,785	0	10,753,278	73.00
74.00	07400	RENAL DIALYSIS	472	472	179	0	681,566	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	231,462	76.00
76.01	03330	ENDOSCOPY	1,925	1,925	511,579	0	1,029,793	76.01
76.02	03040	PRISION CLINIC	7,500	7,500	133,388	0	313,885	76.02
76.03	03050	WOUND CARE	1,728	1,728	65,003	0	759,178	76.03
76.04	03060	OPIC	3,825	3,825	427,625	0	696,146	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,281	10,281	1,920,663	0	3,913,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,951	354,951	35,399,213	-24,647,795	83,540,817	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	607	607	23,475	0	53,417	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,750	3,750	861,071	0	1,041,922	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	2,985	0	0	0	25,166	194.01
194.02	07952	SITTERS	0	0	249,025	0	326,714	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,054,401	3,356,622	8,304,368		24,647,795	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.430748	9.341907	0.227313		0.290015	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			66,647		2,697,398	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001824		0.031739	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/27/2018 2:15 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET 2)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	245,348					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,541	28,944				8.00
9.00	00900	HOUSEKEEPING	1,274	0	237,548			9.00
10.00	01000	DIETARY	5,784	0	5,784	131,869		10.00
11.00	01100	CAFETERIA	3,689	0	3,689	0	28,892,547	11.00
13.00	01300	NURSING ADMINISTRATION	990	0	990	0	620,157	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,701	0	5,701	0	46,683	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,462	16,767	62,462	51,429	5,577,173	30.00
31.00	03100	INTENSIVE CARE UNIT	10,629	3,184	10,629	3,851	1,988,378	31.00
40.00	04000	SUBPROVIDER - IPF	9,596	6,635	9,596	17,578	1,779,372	40.00
41.00	04100	SUBPROVIDER - IRF	11,408	1,780	11,408	6,518	734,038	41.00
43.00	04300	NURSERY	1,044	578	1,044	0	146,228	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,223	0	25,223	0	3,465,246	50.00
51.00	05100	RECOVERY ROOM	1,575	0	1,575	0	478,004	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,182	0	7,182	0	839,062	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,068	0	13,068	0	967,554	54.00
54.01	03630	ULTRA SOUND	406	0	406	0	173,782	54.01
54.02	03440	MAMMOGRAPHY	1,495	0	1,495	0	131,602	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	6,177	0	6,177	0	599,157	55.00
56.00	05600	RADIOISOTOPE	742	0	742	0	183,444	56.00
57.00	05700	CT SCAN	1,602	0	1,602	0	510,039	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,040	0	1,040	0	226,237	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	0	2,293	0	534,976	59.00
60.00	06000	LABORATORY	5,352	0	5,352	0	1,185,857	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	320	0	320	0	18,203	62.00
65.00	06500	RESPIRATORY THERAPY	1,639	0	1,639	0	1,056,996	65.00
66.00	06600	PHYSICAL THERAPY	13,585	0	13,585	0	1,093,137	66.00
69.00	06900	ELECTROCARDIOLOGY	2,192	0	2,192	0	473,681	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,090	0	1,090	0	47,139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,491	0	8,491	0	380,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,685	0	2,685	0	1,443,785	73.00
74.00	07400	RENAL DIALYSIS	472	0	472	0	179	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	1,925	0	1,925	0	511,579	76.01
76.02	03040	PRISION CLINIC	7,500	0	7,500	0	133,388	76.02
76.03	03050	WOUND CARE	1,728	0	1,728	0	65,003	76.03
76.04	03060	OPIC	3,825	0	3,825	0	427,625	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,281	0	10,281	0	1,920,663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	238,006	28,944	233,191	79,376	27,758,976	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	607	0	607	0	23,475	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,750	0	3,750	0	861,071	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	2,985	0	0	52,493	0	194.01
194.02	07952	SITTERS	0	0	0	0	249,025	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,945,762	862,857	2,037,319	2,103,903	533,097	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.309837	29.811256	8.576452	15.954493	0.018451	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,657,607	105,620	82,112	191,182	101,853	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.756146	3.649116	0.345665	1.449787	0.003525	205.00

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	16.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION	12,424,192		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	698,069,350	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,941,419	22,717,250	30.00
31.00	03100	INTENSIVE CARE UNIT	1,710,467	9,165,538	31.00
40.00	04000	SUBPROVIDER - IPF	901,100	25,189,381	40.00
41.00	04100	SUBPROVIDER - IRF	553,590	2,310,130	41.00
43.00	04300	NURSERY	120,706	859,640	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,681,958	89,630,321	50.00
51.00	05100	RECOVERY ROOM	416,430	12,723,357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	757,246	3,491,242	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	56.00
57.00	05700	CT SCAN	0	54,983,436	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	58.00
59.00	05900	CARDIAC CATHETERIZATION	200,953	26,864,974	59.00
60.00	06000	LABORATORY	0	66,576,871	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	62.00
65.00	06500	RESPIRATORY THERAPY	17,679	18,094,921	65.00
66.00	06600	PHYSICAL THERAPY	270	7,001,120	66.00
69.00	06900	ELECTROCARDIOLOGY	142,022	17,980,132	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,616	41,254,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	76.00
76.01	03330	ENDOSCOPY	351,541	19,805,246	76.01
76.02	03040	PRISION CLINIC	3,874	428,705	76.02
76.03	03050	WOUND CARE	315,811	3,777,071	76.03
76.04	03060	OPIC	217,911	5,569,446	76.04
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	59,248,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,393,593	698,069,350	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	30,599	0	194.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,177,505	1,747,157	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.094775	0.002503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,831	190,480	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004494	0.000273	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/27/2018 2:15 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,002,310		17,002,310	0	17,002,310	30.00
31.00	03100	INTENSIVE CARE UNIT	4,894,442		4,894,442	0	4,894,442	31.00
40.00	04000	SUBPROVIDER - IPF	4,493,797		4,493,797	0	4,493,797	40.00
41.00	04100	SUBPROVIDER - IRF	2,224,525		2,224,525	0	2,224,525	41.00
43.00	04300	NURSERY	415,410		415,410	0	415,410	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,605,269		8,605,269	3,517	8,608,786	50.00
51.00	05100	RECOVERY ROOM	1,058,893		1,058,893	0	1,058,893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,339,211		2,339,211	0	2,339,211	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,293,139		3,293,139	0	3,293,139	54.00
54.01	03630	ULTRA SOUND	358,510		358,510	0	358,510	54.01
54.02	03440	MAMMOGRAPHY	438,382		438,382	0	438,382	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,933,365		1,933,365	0	1,933,365	55.00
56.00	05600	RADIOISOTOPE	1,230,718		1,230,718	0	1,230,718	56.00
57.00	05700	CT SCAN	1,339,818		1,339,818	0	1,339,818	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,664		589,664	0	589,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,076,987		1,076,987	0	1,076,987	59.00
60.00	06000	LABORATORY	4,316,500		4,316,500	0	4,316,500	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	914,511		914,511	0	914,511	62.00
65.00	06500	RESPIRATORY THERAPY	2,160,157	0	2,160,157	0	2,160,157	65.00
66.00	06600	PHYSICAL THERAPY	2,808,842	0	2,808,842	24,363	2,833,205	66.00
69.00	06900	ELECTROCARDIOLOGY	1,301,221		1,301,221	0	1,301,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,357		155,357	0	155,357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,797,239		8,797,239	0	8,797,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,480,464		9,480,464	0	9,480,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,264,494		14,264,494	0	14,264,494	73.00
74.00	07400	RENAL DIALYSIS	909,478		909,478	0	909,478	74.00
76.00	03950	LITHOTRIPSY	305,910		305,910	0	305,910	76.00
76.01	03330	ENDOSCOPY	1,491,783		1,491,783	13,046	1,504,829	76.01
76.02	03040	PRISION CLINIC	685,464		685,464	0	685,464	76.02
76.03	03050	WOUND CARE	1,083,674		1,083,674	11,596	1,095,270	76.03
76.04	03060	OPIC	1,081,612		1,081,612	40,355	1,121,967	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,611,216		5,611,216	45,428	5,656,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,386,415		2,386,415		2,386,415	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	109,048,777	0	109,048,777	138,305	109,187,082	200.00
201.00		Less Observation Beds	2,386,415		2,386,415		2,386,415	201.00
202.00		Total (see instructions)	106,662,362	0	106,662,362	138,305	106,800,667	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I | Date/Time Prepared: 1/27/2018 2:15 pm

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,905,207		19,905,207			30.00
31.00	03100	INTENSIVE CARE UNIT	9,165,538		9,165,538			31.00
40.00	04000	SUBPROVIDER - IPF	25,189,381		25,189,381			40.00
41.00	04100	SUBPROVIDER - IRF	2,310,130		2,310,130			41.00
43.00	04300	NURSERY	859,640		859,640			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,931,700	46,698,621	89,630,321	0.096008	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,716,146	8,007,211	12,723,357	0.083224	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,385,412	105,830	3,491,242	0.670023	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,365	10,584,910	15,087,275	0.218273	0.000000	54.00
54.01	03630	ULTRA SOUND	1,117,155	3,512,077	4,629,232	0.077445	0.000000	54.01
54.02	03440	MAMMOGRAPHY	1,027	2,244,289	2,245,316	0.195243	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	597,574	16,423,727	17,021,301	0.113585	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,240,376	11,728,928	12,969,304	0.094895	0.000000	56.00
57.00	05700	CT SCAN	16,686,412	38,297,024	54,983,436	0.024368	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,012,517	10,551,581	13,564,098	0.043472	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,234,013	12,630,961	26,864,974	0.040089	0.000000	59.00
60.00	06000	LABORATORY	30,383,595	36,193,276	66,576,871	0.064835	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,110,458	1,528,730	6,639,188	0.137744	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,765,647	1,329,274	18,094,921	0.119379	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,471,629	1,529,491	7,001,120	0.401199	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	9,810,928	8,169,204	17,980,132	0.072370	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	660,860	775,343	1,436,203	0.108172	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,692,610	16,561,980	41,254,590	0.213243	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,652,273	10,410,208	22,062,481	0.429710	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,075,987	44,614,831	106,690,818	0.133699	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,946,228	181,712	5,127,940	0.177357	0.000000	74.00
76.00	03950	LITHOTRIPSY	27,650	2,897,080	2,924,730	0.104594	0.000000	76.00
76.01	03330	ENDOSCOPY	3,497,664	16,307,582	19,805,246	0.075323	0.000000	76.01
76.02	03040	PRISION CLINIC	0	428,705	428,705	1.598918	0.000000	76.02
76.03	03050	WOUND CARE	42,982	3,734,089	3,777,071	0.286909	0.000000	76.03
76.04	03060	OPIC	61,023	5,508,423	5,569,446	0.194205	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	16,443,558	42,804,535	59,248,093	0.094707	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	667,817	2,144,226	2,812,043	0.848641	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	342,165,502	355,903,848	698,069,350			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	342,165,502	355,903,848	698,069,350			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I | Date/Time Prepared: 1/27/2018 2:15 pm

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		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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.096048	50.00
51.00	05100	RECOVERY ROOM	0.083224	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	54.00
54.01	03630	ULTRA SOUND	0.077445	54.01
54.02	03440	MAMMOGRAPHY	0.195243	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	55.00
56.00	05600	RADIOISOTOPE	0.094895	56.00
57.00	05700	CT SCAN	0.024368	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	59.00
60.00	06000	LABORATORY	0.064835	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	65.00
66.00	06600	PHYSICAL THERAPY	0.404679	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	73.00
74.00	07400	RENAL DIALYSIS	0.177357	74.00
76.00	03950	LITHOTRIPSY	0.104594	76.00
76.01	03330	ENDOSCOPY	0.075981	76.01
76.02	03040	PRISION CLINIC	1.598918	76.02
76.03	03050	WOUND CARE	0.289979	76.03
76.04	03060	OPIC	0.201450	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.095474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	92.00
		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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,002,310		17,002,310	0	17,002,310	30.00
31.00	03100	INTENSIVE CARE UNIT	4,894,442		4,894,442	0	4,894,442	31.00
40.00	04000	SUBPROVIDER - IPF	4,493,797		4,493,797	0	4,493,797	40.00
41.00	04100	SUBPROVIDER - IRF	2,224,525		2,224,525	0	2,224,525	41.00
43.00	04300	NURSERY	415,410		415,410	0	415,410	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,605,269		8,605,269	3,517	8,608,786	50.00
51.00	05100	RECOVERY ROOM	1,058,893		1,058,893	0	1,058,893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,339,211		2,339,211	0	2,339,211	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,293,139		3,293,139	0	3,293,139	54.00
54.01	03630	ULTRA SOUND	358,510		358,510	0	358,510	54.01
54.02	03440	MAMMOGRAPHY	438,382		438,382	0	438,382	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,933,365		1,933,365	0	1,933,365	55.00
56.00	05600	RADIOISOTOPE	1,230,718		1,230,718	0	1,230,718	56.00
57.00	05700	CT SCAN	1,339,818		1,339,818	0	1,339,818	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,664		589,664	0	589,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,076,987		1,076,987	0	1,076,987	59.00
60.00	06000	LABORATORY	4,316,500		4,316,500	0	4,316,500	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	914,511		914,511	0	914,511	62.00
65.00	06500	RESPIRATORY THERAPY	2,160,157	0	2,160,157	0	2,160,157	65.00
66.00	06600	PHYSICAL THERAPY	2,808,842	0	2,808,842	24,363	2,833,205	66.00
69.00	06900	ELECTROCARDIOLOGY	1,301,221		1,301,221	0	1,301,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,357		155,357	0	155,357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,797,239		8,797,239	0	8,797,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,480,464		9,480,464	0	9,480,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,264,494		14,264,494	0	14,264,494	73.00
74.00	07400	RENAL DIALYSIS	909,478		909,478	0	909,478	74.00
76.00	03950	LITHOTRIPSY	305,910		305,910	0	305,910	76.00
76.01	03330	ENDOSCOPY	1,491,783		1,491,783	13,046	1,504,829	76.01
76.02	03040	PRISION CLINIC	685,464		685,464	0	685,464	76.02
76.03	03050	WOUND CARE	1,083,674		1,083,674	11,596	1,095,270	76.03
76.04	03060	OPIC	1,081,612		1,081,612	40,355	1,121,967	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,611,216		5,611,216	45,428	5,656,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,386,415		2,386,415		2,386,415	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	109,048,777	0	109,048,777	138,305	109,187,082	200.00
201.00		Less Observation Beds	2,386,415		2,386,415		2,386,415	201.00
202.00		Total (see instructions)	106,662,362	0	106,662,362	138,305	106,800,667	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,905,207		19,905,207			30.00
31.00	03100	INTENSIVE CARE UNIT	9,165,538		9,165,538			31.00
40.00	04000	SUBPROVIDER - IPF	25,189,381		25,189,381			40.00
41.00	04100	SUBPROVIDER - IRF	2,310,130		2,310,130			41.00
43.00	04300	NURSERY	859,640		859,640			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,931,700	46,698,621	89,630,321	0.096008	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,716,146	8,007,211	12,723,357	0.083224	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,385,412	105,830	3,491,242	0.670023	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,365	10,584,910	15,087,275	0.218273	0.000000	54.00
54.01	03630	ULTRA SOUND	1,117,155	3,512,077	4,629,232	0.077445	0.000000	54.01
54.02	03440	MAMMOGRAPHY	1,027	2,244,289	2,245,316	0.195243	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	597,574	16,423,727	17,021,301	0.113585	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,240,376	11,728,928	12,969,304	0.094895	0.000000	56.00
57.00	05700	CT SCAN	16,686,412	38,297,024	54,983,436	0.024368	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,012,517	10,551,581	13,564,098	0.043472	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,234,013	12,630,961	26,864,974	0.040089	0.000000	59.00
60.00	06000	LABORATORY	30,383,595	36,193,276	66,576,871	0.064835	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,110,458	1,528,730	6,639,188	0.137744	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,765,647	1,329,274	18,094,921	0.119379	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,471,629	1,529,491	7,001,120	0.401199	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	9,810,928	8,169,204	17,980,132	0.072370	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	660,860	775,343	1,436,203	0.108172	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,692,610	16,561,980	41,254,590	0.213243	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,652,273	10,410,208	22,062,481	0.429710	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,075,987	44,614,831	106,690,818	0.133699	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,946,228	181,712	5,127,940	0.177357	0.000000	74.00
76.00	03950	LITHOTRIPSY	27,650	2,897,080	2,924,730	0.104594	0.000000	76.00
76.01	03330	ENDOSCOPY	3,497,664	16,307,582	19,805,246	0.075323	0.000000	76.01
76.02	03040	PRISION CLINIC	0	428,705	428,705	1.598918	0.000000	76.02
76.03	03050	WOUND CARE	42,982	3,734,089	3,777,071	0.286909	0.000000	76.03
76.04	03060	OPIC	61,023	5,508,423	5,569,446	0.194205	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	16,443,558	42,804,535	59,248,093	0.094707	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	667,817	2,144,226	2,812,043	0.848641	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	342,165,502	355,903,848	698,069,350			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	342,165,502	355,903,848	698,069,350			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	LITHOTRIPSY	0.000000	76.00
76.01	03330	ENDOSCOPY	0.000000	76.01
76.02	03040	PRISION CLINIC	0.000000	76.02
76.03	03050	WOUND CARE	0.000000	76.03
76.04	03060	OPIC	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		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: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part I Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,066,511	0	2,066,511	19,265	107.27	30.00
31.00	INTENSIVE CARE UNIT	404,385		404,385	3,184	127.01	31.00
40.00	SUBPROVIDER - IPF	394,677	0	394,677	6,635	59.48	40.00
41.00	SUBPROVIDER - IRF	345,512	0	345,512	1,780	194.11	41.00
43.00	NURSERY	38,085		38,085	578	65.89	43.00
200.00	Total (lines 30-199)	3,249,170		3,249,170	31,442		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	9,342	1,002,116	30.00
31.00	INTENSIVE CARE UNIT	1,542	195,849	31.00
40.00	SUBPROVIDER - IPF	1,623	96,536	40.00
41.00	SUBPROVIDER - IRF	1,119	217,209	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	13,626	1,511,710	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part II Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	856,016	89,630,321	0.009551	20,137,449	192,333	50.00
51.00	05100	RECOVERY ROOM	69,743	12,723,357	0.005481	2,250,997	12,338	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,196	3,491,242	0.067940	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402,149	15,087,275	0.026655	2,303,523	61,400	54.00
54.01	03630	ULTRA SOUND	20,381	4,629,232	0.004403	528,654	2,328	54.01
54.02	03440	MAMMOGRAPHY	47,735	2,245,316	0.021260	1,021	22	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	202,144	17,021,301	0.011876	451,878	5,367	55.00
56.00	05600	RADIOISOTOPE	51,705	12,969,304	0.003987	846,864	3,376	56.00
57.00	05700	CT SCAN	85,480	54,983,436	0.001555	8,360,116	13,000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,408	13,564,098	0.003200	1,371,326	4,388	58.00
59.00	05900	CARDIAC CATHETERIZATION	90,188	26,864,974	0.003357	8,475,217	28,451	59.00
60.00	06000	LABORATORY	254,352	66,576,871	0.003820	15,257,656	58,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,662	6,639,188	0.004769	2,799,383	13,350	62.00
65.00	06500	RESPIRATORY THERAPY	101,467	18,094,921	0.005607	9,600,581	53,830	65.00
66.00	06600	PHYSICAL THERAPY	401,647	7,001,120	0.057369	1,634,748	93,784	66.00
69.00	06900	ELECTROCARDIOLOGY	90,977	17,980,132	0.005060	5,828,225	29,491	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,481	1,436,203	0.021223	323,753	6,871	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,662	41,254,590	0.010439	13,095,381	136,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,918	22,062,481	0.010784	6,292,830	67,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	444,804	106,690,818	0.004169	29,338,540	122,312	73.00
74.00	07400	RENAL DIALYSIS	34,773	5,127,940	0.006781	3,419,398	23,187	74.00
76.00	03950	LITHOTRIPSY	8,144	2,924,730	0.002785	27,650	77	76.00
76.01	03330	ENDOSCOPY	90,291	19,805,246	0.004559	1,901,675	8,670	76.01
76.02	03040	PRISION CLINIC	197,367	428,705	0.460380	0	0	76.02
76.03	03050	WOUND CARE	69,877	3,777,071	0.018500	34,735	643	76.03
76.04	03060	OPIC	122,026	5,569,446	0.021910	16,086	352	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	409,670	59,248,093	0.006914	7,151,093	49,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	290,052	2,812,043	0.103146	389,370	40,162	92.00
200.00		Total (lines 50-199)	5,352,315	640,639,454		141,838,149	1,028,024	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part III Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	19,265	0.00	9,342	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,184	0.00	1,542	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,635	0.00	1,623	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,780	0.00	1,119	0	41.00
43.00	04300	NURSERY	578	0.00	0	0	43.00
200.00		Total (lines 30-199)	31,442		13,626	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,630,321	0.000000	0.000000	20,137,449	50.00
51.00	05100	RECOVERY ROOM	0	12,723,357	0.000000	0.000000	2,250,997	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,491,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	0.000000	0.000000	2,303,523	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	0.000000	0.000000	528,654	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	0.000000	0.000000	1,021	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	0.000000	0.000000	451,878	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	0.000000	0.000000	846,864	56.00
57.00	05700	CT SCAN	0	54,983,436	0.000000	0.000000	8,360,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	0.000000	0.000000	1,371,326	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,864,974	0.000000	0.000000	8,475,217	59.00
60.00	06000	LABORATORY	0	66,576,871	0.000000	0.000000	15,257,656	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	0.000000	0.000000	2,799,383	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,094,921	0.000000	0.000000	9,600,581	65.00
66.00	06600	PHYSICAL THERAPY	0	7,001,120	0.000000	0.000000	1,634,748	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,980,132	0.000000	0.000000	5,828,225	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	0.000000	0.000000	323,753	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,254,590	0.000000	0.000000	13,095,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	0.000000	0.000000	6,292,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	0.000000	0.000000	29,338,540	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	0.000000	0.000000	3,419,398	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	0.000000	0.000000	27,650	76.00
76.01	03330	ENDOSCOPY	0	19,805,246	0.000000	0.000000	1,901,675	76.01
76.02	03040	PRISION CLINIC	0	428,705	0.000000	0.000000	0	76.02
76.03	03050	WOUND CARE	0	3,777,071	0.000000	0.000000	34,735	76.03
76.04	03060	OPIC	0	5,569,446	0.000000	0.000000	16,086	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,248,093	0.000000	0.000000	7,151,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0.000000	389,370	92.00
200.00		Total (lines 50-199)	0	640,639,454			141,838,149	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	14,041,263	0	50.00
51.00	05100	RECOVERY ROOM	0	2,234,736	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,534,765	0	54.00
54.01	03630	ULTRA SOUND	0	883,934	0	54.01
54.02	03440	MAMMOGRAPHY	0	172,768	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,013,054	0	55.00
56.00	05600	RADIOISOTOPE	0	5,113,209	0	56.00
57.00	05700	CT SCAN	0	11,003,315	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,070,594	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,217,442	0	59.00
60.00	06000	LABORATORY	0	7,606,158	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	619,659	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	233,251	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,141	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,664,817	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	194,851	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,904,259	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,794,901	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,850,329	0	73.00
74.00	07400	RENAL DIALYSIS	0	116,185	0	74.00
76.00	03950	LITHOTRIPSY	0	718,894	0	76.00
76.01	03330	ENDOSCOPY	0	7,205,081	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	76.02
76.03	03050	WOUND CARE	0	1,497,966	0	76.03
76.04	03060	OPIC	0	2,354,187	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	7,953,753	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	404,537	0	92.00
200.00		Total (lines 50-199)	0	112,430,049	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.096008	14,041,263	0	0	1,348,074	50.00
51.00	05100	RECOVERY ROOM	0.083224	2,234,736	0	0	185,984	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	2,534,765	0	0	553,271	54.00
54.01	03630	ULTRA SOUND	0.077445	883,934	0	0	68,456	54.01
54.02	03440	MAMMOGRAPHY	0.195243	172,768	0	0	33,732	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	9,013,054	0	0	1,023,748	55.00
56.00	05600	RADIOISOTOPE	0.094895	5,113,209	0	0	485,218	56.00
57.00	05700	CT SCAN	0.024368	11,003,315	0	0	268,129	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	3,070,594	0	0	133,485	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	7,217,442	0	0	289,340	59.00
60.00	06000	LABORATORY	0.064835	7,606,158	664	0	493,145	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	619,659	0	0	85,354	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	233,251	0	0	27,845	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	26,141	0	0	10,488	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	2,664,817	0	0	192,853	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	194,851	0	0	21,077	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	5,904,259	0	0	1,259,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	3,794,901	0	0	1,630,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	15,850,329	0	118,618	2,119,173	73.00
74.00	07400	RENAL DIALYSIS	0.177357	116,185	0	0	20,606	74.00
76.00	03950	LITHOTRIPSY	0.104594	718,894	0	0	75,192	76.00
76.01	03330	ENDOSCOPY	0.075323	7,205,081	0	0	542,708	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.286909	1,497,966	0	0	429,780	76.03
76.04	03060	OPIC	0.194205	2,354,187	0	0	457,195	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094707	7,953,753	0	0	753,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	404,537	0	0	343,307	92.00
200.00		Subtotal (see instructions)		112,430,049	664	118,618	12,851,185	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		112,430,049	664	118,618	12,851,185	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046

Period: From 09/01/2016 To 08/31/2017

Worksheet D Part V
Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
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	43	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,859	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	43	15,859	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	43	15,859	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part II | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IPF | 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	856,016	89,630,321	0.009551	1,386	13	50.00
51.00	05100	RECOVERY ROOM	69,743	12,723,357	0.005481	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,196	3,491,242	0.067940	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402,149	15,087,275	0.026655	16,127	430	54.00
54.01	03630	ULTRA SOUND	20,381	4,629,232	0.004403	4,073	18	54.01
54.02	03440	MAMMOGRAPHY	47,735	2,245,316	0.021260	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	202,144	17,021,301	0.011876	0	0	55.00
56.00	05600	RADIOISOTOPE	51,705	12,969,304	0.003987	0	0	56.00
57.00	05700	CT SCAN	85,480	54,983,436	0.001555	109,325	170	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,408	13,564,098	0.003200	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	90,188	26,864,974	0.003357	0	0	59.00
60.00	06000	LABORATORY	254,352	66,576,871	0.003820	597,889	2,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,662	6,639,188	0.004769	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	101,467	18,094,921	0.005607	51,165	287	65.00
66.00	06600	PHYSICAL THERAPY	401,647	7,001,120	0.057369	14,410	827	66.00
69.00	06900	ELECTROCARDIOLOGY	90,977	17,980,132	0.005060	36,933	187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,481	1,436,203	0.021223	9,092	193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,662	41,254,590	0.010439	8,668	90	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,918	22,062,481	0.010784	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	444,804	106,690,818	0.004169	732,586	3,054	73.00
74.00	07400	RENAL DIALYSIS	34,773	5,127,940	0.006781	86,928	589	74.00
76.00	03950	LITHOTRIPSY	8,144	2,924,730	0.002785	0	0	76.00
76.01	03330	ENDOSCOPY	90,291	19,805,246	0.004559	0	0	76.01
76.02	03040	PRISION CLINIC	197,367	428,705	0.460380	0	0	76.02
76.03	03050	WOUND CARE	69,877	3,777,071	0.018500	0	0	76.03
76.04	03060	OPIC	122,026	5,569,446	0.021910	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	409,670	59,248,093	0.006914	420,583	2,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	1,354	0	92.00
200.00		Total (lines 50-199)	5,062,263	640,639,454		2,090,519	11,050	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	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	89,630,321	0.000000	0.000000	1,386	50.00
51.00	05100	RECOVERY ROOM	0	12,723,357	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,491,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	0.000000	0.000000	16,127	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	0.000000	0.000000	4,073	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	54,983,436	0.000000	0.000000	109,325	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,864,974	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	66,576,871	0.000000	0.000000	597,889	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,094,921	0.000000	0.000000	51,165	65.00
66.00	06600	PHYSICAL THERAPY	0	7,001,120	0.000000	0.000000	14,410	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,980,132	0.000000	0.000000	36,933	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	0.000000	0.000000	9,092	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,254,590	0.000000	0.000000	8,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	0.000000	0.000000	732,586	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	0.000000	0.000000	86,928	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	19,805,246	0.000000	0.000000	0	76.01
76.02	03040	PRISION CLINIC	0	428,705	0.000000	0.000000	0	76.02
76.03	03050	WOUND CARE	0	3,777,071	0.000000	0.000000	0	76.03
76.04	03060	OPIC	0	5,569,446	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,248,093	0.000000	0.000000	420,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0.000000	1,354	92.00
200.00		Total (lines 50-199)	0	640,639,454			2,090,519	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm

Component CCN: 15-S046

Title XVIII | Subprovider - IPF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	3,500	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	744	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	138	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,415	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	76.03
76.04	03060	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,840	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	11,637	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IPF | 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	0.096008	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.083224	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.077445	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094895	0	0	0	0	56.00
57.00	05700	CT SCAN	0.024368	3,500	0	0	85	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	0	0	59.00
60.00	06000	LABORATORY	0.064835	744	0	0	48	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	138	0	0	29	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	5,415	0	5,517	724	73.00
74.00	07400	RENAL DIALYSIS	0.177357	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.075323	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.286909	0	0	0	0	76.03
76.04	03060	OPIC	0.194205	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094707	1,840	0	0	174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	0	0	0	0	92.00
200.00		Subtotal (see instructions)		11,637	0	5,517	1,060	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		11,637	0	5,517	1,060	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	738	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	738	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	738	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part II

Component CCN: 15-T046 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	856,016	89,630,321	0.009551	97,969	936	50.00
51.00	05100	RECOVERY ROOM	69,743	12,723,357	0.005481	19,232	105	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,196	3,491,242	0.067940	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	402,149	15,087,275	0.026655	46,540	1,241	54.00
54.01	03630	ULTRA SOUND	20,381	4,629,232	0.004403	4,970	22	54.01
54.02	03440	MAMMOGRAPHY	47,735	2,245,316	0.021260	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	202,144	17,021,301	0.011876	4,569	54	55.00
56.00	05600	RADIOISOTOPE	51,705	12,969,304	0.003987	9,410	38	56.00
57.00	05700	CT SCAN	85,480	54,983,436	0.001555	56,323	88	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,408	13,564,098	0.003200	22,957	73	58.00
59.00	05900	CARDIAC CATHETERIZATION	90,188	26,864,974	0.003357	0	0	59.00
60.00	06000	LABORATORY	254,352	66,576,871	0.003820	300,478	1,148	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,662	6,639,188	0.004769	28,973	138	62.00
65.00	06500	RESPIRATORY THERAPY	101,467	18,094,921	0.005607	82,728	464	65.00
66.00	06600	PHYSICAL THERAPY	401,647	7,001,120	0.057369	1,761,915	101,079	66.00
69.00	06900	ELECTROCARDIOLOGY	90,977	17,980,132	0.005060	37,474	190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,481	1,436,203	0.021223	3,108	66	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,662	41,254,590	0.010439	326,129	3,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,918	22,062,481	0.010784	8,967	97	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	444,804	106,690,818	0.004169	926,544	3,863	73.00
74.00	07400	RENAL DIALYSIS	34,773	5,127,940	0.006781	161,294	1,094	74.00
76.00	03950	LITHOTRIPSY	8,144	2,924,730	0.002785	0	0	76.00
76.01	03330	ENDOSCOPY	90,291	19,805,246	0.004559	0	0	76.01
76.02	03040	PRISION CLINIC	197,367	428,705	0.460380	0	0	76.02
76.03	03050	WOUND CARE	69,877	3,777,071	0.018500	0	0	76.03
76.04	03060	OPIC	122,026	5,569,446	0.021910	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	409,670	59,248,093	0.006914	2,748	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0	0	92.00
200.00		Total (lines 50-199)	5,062,263	640,639,454		3,902,328	114,119	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm
Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	89,630,321	0.000000	0.000000	97,969	50.00
51.00	05100	RECOVERY ROOM	0	12,723,357	0.000000	0.000000	19,232	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,491,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	0.000000	0.000000	46,540	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	0.000000	0.000000	4,970	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	0.000000	0.000000	4,569	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	0.000000	0.000000	9,410	56.00
57.00	05700	CT SCAN	0	54,983,436	0.000000	0.000000	56,323	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	0.000000	0.000000	22,957	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,864,974	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	66,576,871	0.000000	0.000000	300,478	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	0.000000	0.000000	28,973	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,094,921	0.000000	0.000000	82,728	65.00
66.00	06600	PHYSICAL THERAPY	0	7,001,120	0.000000	0.000000	1,761,915	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,980,132	0.000000	0.000000	37,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	0.000000	0.000000	3,108	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,254,590	0.000000	0.000000	326,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	0.000000	0.000000	8,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	0.000000	0.000000	926,544	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	0.000000	0.000000	161,294	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	19,805,246	0.000000	0.000000	0	76.01
76.02	03040	PRISION CLINIC	0	428,705	0.000000	0.000000	0	76.02
76.03	03050	WOUND CARE	0	3,777,071	0.000000	0.000000	0	76.03
76.04	03060	OPIC	0	5,569,446	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,248,093	0.000000	0.000000	2,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	640,639,454			3,902,328	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
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	1,268	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	76.03
76.04	03060	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	1,268	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.096008	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.083224	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.077445	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094895	0	0	0	0	56.00
57.00	05700	CT SCAN	0.024368	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	0	0	59.00
60.00	06000	LABORATORY	0.064835	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	1,268	0	1,624	170	73.00
74.00	07400	RENAL DIALYSIS	0.177357	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.075323	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.286909	0	0	0	0	76.03
76.04	03060	OPIC	0.194205	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094707	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,268	0	1,624	170	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,268	0	1,624	170	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	217	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	217	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	217	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part III Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		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
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	19,265	0.00	1,154	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,184	0.00	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,635	0.00	2,848	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,780	0.00	113	0	41.00
43.00	04300	NURSERY	578	0.00	0	0	43.00
200.00		Total (lines 30-199)	31,442		4,115	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Hospital	Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		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	89,630,321	0.000000	0.000000	6,890,772	50.00
51.00	05100	RECOVERY ROOM	0	12,723,357	0.000000	0.000000	739,074	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,491,242	0.000000	0.000000	1,688,692	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	0.000000	0.000000	618,992	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	0.000000	0.000000	185,245	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	0.000000	0.000000	98,383	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	0.000000	0.000000	104,969	56.00
57.00	05700	CT SCAN	0	54,983,436	0.000000	0.000000	2,292,716	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	0.000000	0.000000	380,394	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,864,974	0.000000	0.000000	1,196,283	59.00
60.00	06000	LABORATORY	0	66,576,871	0.000000	0.000000	3,889,044	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	0.000000	0.000000	726,887	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,094,921	0.000000	0.000000	2,878,705	65.00
66.00	06600	PHYSICAL THERAPY	0	7,001,120	0.000000	0.000000	208,075	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,980,132	0.000000	0.000000	1,148,930	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	0.000000	0.000000	73,889	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,254,590	0.000000	0.000000	2,818,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	0.000000	0.000000	1,504,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	0.000000	0.000000	9,570,255	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	0.000000	0.000000	319,774	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	19,805,246	0.000000	0.000000	392,223	76.01
76.02	03040	PRISION CLINIC	0	428,705	0.000000	0.000000	0	76.02
76.03	03050	WOUND CARE	0	3,777,071	0.000000	0.000000	3,106	76.03
76.04	03060	OPIC	0	5,569,446	0.000000	0.000000	28,835	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,248,093	0.000000	0.000000	2,274,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0.000000	104,557	92.00
200.00		Total (lines 50-199)	0	640,639,454			40,136,414	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	76.03
76.04	03060	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.096008	0	0	10,420,829	0	50.00
51.00	05100	RECOVERY ROOM	0.083224	0	0	1,690,307	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	61,504	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	0	0	2,939,897	0	54.00
54.01	03630	ULTRA SOUND	0.077445	0	0	810,836	0	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	166,561	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	0	0	1,798,015	0	55.00
56.00	05600	RADIOISOTOPE	0.094895	0	0	1,662,730	0	56.00
57.00	05700	CT SCAN	0.024368	0	0	8,757,052	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	0	0	1,670,802	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	1,070,330	0	59.00
60.00	06000	LABORATORY	0.064835	0	0	9,302,567	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	0	0	207,394	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	0	0	453,535	0	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	0	0	288,801	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	0	0	1,443,895	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	0	0	305,533	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	0	0	2,703,289	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	0	0	2,150,896	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	0	0	7,231,513	0	73.00
74.00	07400	RENAL DIALYSIS	0.177357	0	0	4,931	0	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	438,299	0	76.00
76.01	03330	ENDOSCOPY	0.075323	0	0	1,277,771	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.286909	0	0	648,586	0	76.03
76.04	03060	OPIC	0.194205	0	0	675,462	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094707	0	0	14,082,491	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	0	0	728,558	0	92.00
200.00		Subtotal (see instructions)		0	0	72,992,384	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	72,992,384	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,000,483	50.00
51.00	05100	RECOVERY ROOM	0	140,674	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,209	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	641,700	54.00
54.01	03630	ULTRA SOUND	0	62,795	54.01
54.02	03440	MAMMOGRAPHY	0	32,520	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	204,228	55.00
56.00	05600	RADIOISOTOPE	0	157,785	56.00
57.00	05700	CT SCAN	0	213,392	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	72,633	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	42,908	59.00
60.00	06000	LABORATORY	0	603,132	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	28,567	62.00
65.00	06500	RESPIRATORY THERAPY	0	54,143	65.00
66.00	06600	PHYSICAL THERAPY	0	115,867	66.00
69.00	06900	ELECTROCARDIOLOGY	0	104,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	576,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	924,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	966,846	73.00
74.00	07400	RENAL DIALYSIS	0	875	74.00
76.00	03950	LITHOTRIPSY	0	45,843	76.00
76.01	03330	ENDOSCOPY	0	96,246	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	186,085	76.03
76.04	03060	OPIC	0	131,178	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	1,333,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	618,284	92.00
200.00		Subtotal (see instructions)	0	8,429,367	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	8,429,367	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovider - IPF	Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | Cost

		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	89,630,321	0.000000	0.000000	17,509	50.00
51.00	05100	RECOVERY ROOM	0	12,723,357	0.000000	0.000000	4,585	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,491,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	0.000000	0.000000	38,070	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	0.000000	0.000000	5,873	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	0.000000	0.000000	1,485	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	54,983,436	0.000000	0.000000	157,244	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	0.000000	0.000000	11,824	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,864,974	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	66,576,871	0.000000	0.000000	1,261,877	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	0.000000	0.000000	1,525	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,094,921	0.000000	0.000000	72,056	65.00
66.00	06600	PHYSICAL THERAPY	0	7,001,120	0.000000	0.000000	3,455	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,980,132	0.000000	0.000000	43,107	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	0.000000	0.000000	6,215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,254,590	0.000000	0.000000	14,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	0.000000	0.000000	1,080,895	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	0.000000	0.000000	0	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	19,805,246	0.000000	0.000000	0	76.01
76.02	03040	PRISION CLINIC	0	428,705	0.000000	0.000000	0	76.02
76.03	03050	WOUND CARE	0	3,777,071	0.000000	0.000000	0	76.03
76.04	03060	OPIC	0	5,569,446	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,248,093	0.000000	0.000000	950,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0.000000	13,856	92.00
200.00		Total (lines 50-199)	0	640,639,454			3,684,683	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	76.03
76.04	03060	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IRF | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IRF | Cost

		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	89,630,321	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	12,723,357	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,491,242	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,087,275	0.000000	0.000000	858	54.00
54.01	03630	ULTRA SOUND	0	4,629,232	0.000000	0.000000	0	54.01
54.02	03440	MAMMOGRAPHY	0	2,245,316	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,021,301	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	12,969,304	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	54,983,436	0.000000	0.000000	3,570	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,564,098	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,864,974	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	66,576,871	0.000000	0.000000	10,065	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,639,188	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,094,921	0.000000	0.000000	12,960	65.00
66.00	06600	PHYSICAL THERAPY	0	7,001,120	0.000000	0.000000	119,774	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,980,132	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,436,203	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,254,590	0.000000	0.000000	657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,062,481	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,690,818	0.000000	0.000000	53,918	73.00
74.00	07400	RENAL DIALYSIS	0	5,127,940	0.000000	0.000000	0	74.00
76.00	03950	LITHOTRIPSY	0	2,924,730	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	19,805,246	0.000000	0.000000	0	76.01
76.02	03040	PRISION CLINIC	0	428,705	0.000000	0.000000	0	76.02
76.03	03050	WOUND CARE	0	3,777,071	0.000000	0.000000	0	76.03
76.04	03060	OPIC	0	5,569,446	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,248,093	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,812,043	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	640,639,454			201,802	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IRF | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	76.03
76.04	03060	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,265	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,265	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	16,561	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)	9,342	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)	17,002,310	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)	17,002,310	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)	17,002,310	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)	882.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,244,782	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)	8,244,782	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,894,442	3,184	1,537.20	1,542	2,370,362	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)	18,238,968	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,854,112	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)	1,197,965	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,028,024	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,225,989	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	26,628,123	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)	2,704	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	882.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,386,415	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,066,511	17,002,310	0.121543	2,386,415	290,052	90.00
91.00	Nursing School cost	0	17,002,310	0.000000	2,386,415	0	91.00
92.00	Allied health cost	0	17,002,310	0.000000	2,386,415	0	92.00
93.00	All other Medical Education	0	17,002,310	0.000000	2,386,415	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	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)	6,635	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,635	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)	6,635	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)	1,623	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)	4,493,797	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)	4,493,797	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)	4,493,797	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)	677.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,099,242	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,099,242	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1
Component CCN: 15-S046 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IPF | 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)	217,506	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,316,748	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)	96,536	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,050	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	107,586	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,209,162	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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IPF | 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	394,677	4,493,797	0.087827	0	0	90.00
91.00	Nursing School cost	0	4,493,797	0.000000	0	0	91.00
92.00	Allied health cost	0	4,493,797	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,493,797	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,780	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,780	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,780	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)	1,119	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)	2,224,525	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)	2,224,525	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)	2,224,525	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)	1,249.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,398,448	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,398,448	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,000,887	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,399,335	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)	217,209	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	114,119	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	331,328	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,068,007	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	345,512	2,224,525	0.155319	0	0	90.00
91.00	Nursing School cost	0	2,224,525	0.000000	0	0	91.00
92.00	Allied health cost	0	2,224,525	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,224,525	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,265	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,265	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	16,561	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)	1,154	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)	578	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)	17,002,310	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)	17,002,310	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)	17,002,310	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)	882.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,018,463	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,018,463	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	415,410	578	718.70	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,894,442	3,184	1,537.20	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)	5,939,757	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,958,220	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)	2,704	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	882.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,386,415	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,066,511	17,002,310	0.121543	2,386,415	290,052	90.00
91.00	Nursing School cost	0	17,002,310	0.000000	2,386,415	0	91.00
92.00	Allied health cost	0	17,002,310	0.000000	2,386,415	0	92.00
93.00	All other Medical Education	0	17,002,310	0.000000	2,386,415	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | 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)	6,635	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,635	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)	6,635	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,848	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)	578	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)	4,493,797	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)	4,493,797	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)	4,493,797	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)	677.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,928,922	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,928,922	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | 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)	360,499	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,289,421	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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | 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	394,677	4,493,797	0.087827	0	0	90.00
91.00	Nursing School cost	0	4,493,797	0.000000	0	0	91.00
92.00	Allied health cost	0	4,493,797	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,493,797	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,780	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,780	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,780	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)	113	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)	578	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)	2,224,525	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)	2,224,525	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)	2,224,525	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)	1,249.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	141,219	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)	141,219	41.00

COMPUTATION OF INPATIENT OPERATING COST

	Provider CCN: 15-0046	Period: From 09/01/2016	Worksheet D-1
	Component CCN: 15-T046	To 08/31/2017	Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovider - IRF	Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	57,876	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	199,095	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	345,512	2,224,525	0.155319	0	0	90.00
91.00	Nursing School cost	0	2,224,525	0.000000	0	0	91.00
92.00	Allied health cost	0	2,224,525	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,224,525	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,600,823		30.00
31.00	03100	INTENSIVE CARE UNIT		4,641,915		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096048	20,137,449	1,934,162	50.00
51.00	05100	RECOVERY ROOM	0.083224	2,250,997	187,337	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	2,303,523	502,797	54.00
54.01	03630	ULTRA SOUND	0.077445	528,654	40,942	54.01
54.02	03440	MAMMOGRAPHY	0.195243	1,021	199	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	451,878	51,327	55.00
56.00	05600	RADIOISOTOPE	0.094895	846,864	80,363	56.00
57.00	05700	CT SCAN	0.024368	8,360,116	203,719	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	1,371,326	59,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	8,475,217	339,763	59.00
60.00	06000	LABORATORY	0.064835	15,257,656	989,230	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	2,799,383	385,598	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	9,600,581	1,146,108	65.00
66.00	06600	PHYSICAL THERAPY	0.404679	1,634,748	661,548	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	5,828,225	421,789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	323,753	35,021	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	13,095,381	2,792,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	6,292,830	2,704,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	29,338,540	3,922,533	73.00
74.00	07400	RENAL DIALYSIS	0.177357	3,419,398	606,454	74.00
76.00	03950	LITHOTRIPSY	0.104594	27,650	2,892	76.00
76.01	03330	ENDOSCOPY	0.075981	1,901,675	144,491	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	76.02
76.03	03050	WOUND CARE	0.289979	34,735	10,072	76.03
76.04	03060	OPIC	0.201450	16,086	3,241	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.095474	7,151,093	682,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	389,370	330,435	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		141,838,149	18,238,968	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)		141,838,149		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-3 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	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		6,124,507		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096048	1,386	133	50.00
51.00	05100	RECOVERY ROOM	0.083224	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	16,127	3,520	54.00
54.01	03630	ULTRA SOUND	0.077445	4,073	315	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094895	0	0	56.00
57.00	05700	CT SCAN	0.024368	109,325	2,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	59.00
60.00	06000	LABORATORY	0.064835	597,889	38,764	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	51,165	6,108	65.00
66.00	06600	PHYSICAL THERAPY	0.404679	14,410	5,831	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	36,933	2,673	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	9,092	983	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	8,668	1,848	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	732,586	97,946	73.00
74.00	07400	RENAL DIALYSIS	0.177357	86,928	15,417	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	76.00
76.01	03330	ENDOSCOPY	0.075981	0	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	76.02
76.03	03050	WOUND CARE	0.289979	0	0	76.03
76.04	03060	OPIC	0.201450	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.095474	420,583	40,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	1,354	1,149	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,090,519	217,506	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)		2,090,519		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3

Component CCN: 15-T046 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,447,475		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096048	97,969	9,410	50.00
51.00	05100	RECOVERY ROOM	0.083224	19,232	1,601	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	46,540	10,158	54.00
54.01	03630	ULTRA SOUND	0.077445	4,970	385	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	4,569	519	55.00
56.00	05600	RADIOISOTOPE	0.094895	9,410	893	56.00
57.00	05700	CT SCAN	0.024368	56,323	1,372	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	22,957	998	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	59.00
60.00	06000	LABORATORY	0.064835	300,478	19,481	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	28,973	3,991	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	82,728	9,876	65.00
66.00	06600	PHYSICAL THERAPY	0.404679	1,761,915	713,010	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	37,474	2,712	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	3,108	336	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	326,129	69,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	8,967	3,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	926,544	123,878	73.00
74.00	07400	RENAL DIALYSIS	0.177357	161,294	28,607	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	76.00
76.01	03330	ENDOSCOPY	0.075981	0	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	76.02
76.03	03050	WOUND CARE	0.289979	0	0	76.03
76.04	03060	OPIC	0.201450	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.095474	2,748	262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,902,328	1,000,887	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)		3,902,328		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,777,362		30.00
31.00	03100	INTENSIVE CARE UNIT		1,358,386		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		503,729		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096008	6,890,772	661,569	50.00
51.00	05100	RECOVERY ROOM	0.083224	739,074	61,509	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	1,688,692	1,131,462	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	618,992	135,109	54.00
54.01	03630	ULTRA SOUND	0.077445	185,245	14,346	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	98,383	11,175	55.00
56.00	05600	RADIOISOTOPE	0.094895	104,969	9,961	56.00
57.00	05700	CT SCAN	0.024368	2,292,716	55,869	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	380,394	16,536	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	1,196,283	47,958	59.00
60.00	06000	LABORATORY	0.064835	3,889,044	252,146	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	726,887	100,124	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	2,878,705	343,657	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	208,075	83,479	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	1,148,930	83,148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	73,889	7,993	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	2,818,018	600,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	1,504,225	646,381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	9,570,255	1,279,534	73.00
74.00	07400	RENAL DIALYSIS	0.177357	319,774	56,714	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	76.00
76.01	03330	ENDOSCOPY	0.075323	392,223	29,543	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	76.02
76.03	03050	WOUND CARE	0.286909	3,106	891	76.03
76.04	03060	OPIC	0.194205	28,835	5,600	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.094707	2,274,371	215,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	104,557	88,731	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,136,414	5,939,757	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)		40,136,414		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		10,797,274		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096008	17,509	1,681	50.00
51.00	05100	RECOVERY ROOM	0.083224	4,585	382	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	38,070	8,310	54.00
54.01	03630	ULTRA SOUND	0.077445	5,873	455	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	1,485	169	55.00
56.00	05600	RADIOISOTOPE	0.094895	0	0	56.00
57.00	05700	CT SCAN	0.024368	157,244	3,832	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	11,824	514	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	59.00
60.00	06000	LABORATORY	0.064835	1,261,877	81,814	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	1,525	210	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	72,056	8,602	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	3,455	1,386	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	43,107	3,120	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	6,215	672	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	14,134	3,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	1,080,895	144,515	73.00
74.00	07400	RENAL DIALYSIS	0.177357	0	0	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	76.00
76.01	03330	ENDOSCOPY	0.075323	0	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	76.02
76.03	03050	WOUND CARE	0.286909	0	0	76.03
76.04	03060	OPIC	0.194205	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.094707	950,973	90,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	13,856	11,759	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,684,683	360,499	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)		3,684,683		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet D-3 Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovider - IRF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		103,943		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.096008	0	0	50.00
51.00	05100	RECOVERY ROOM	0.083224	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.670023	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218273	858	187	54.00
54.01	03630	ULTRA SOUND	0.077445	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.195243	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113585	0	0	55.00
56.00	05600	RADIOISOTOPE	0.094895	0	0	56.00
57.00	05700	CT SCAN	0.024368	3,570	87	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043472	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040089	0	0	59.00
60.00	06000	LABORATORY	0.064835	10,065	653	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.137744	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.119379	12,960	1,547	65.00
66.00	06600	PHYSICAL THERAPY	0.401199	119,774	48,053	66.00
69.00	06900	ELECTROCARDIOLOGY	0.072370	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.108172	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213243	657	140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.429710	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.133699	53,918	7,209	73.00
74.00	07400	RENAL DIALYSIS	0.177357	0	0	74.00
76.00	03950	LITHOTRIPSY	0.104594	0	0	76.00
76.01	03330	ENDOSCOPY	0.075323	0	0	76.01
76.02	03040	PRISION CLINIC	1.598918	0	0	76.02
76.03	03050	WOUND CARE	0.286909	0	0	76.03
76.04	03060	OPIC	0.194205	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.094707	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.848641	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		201,802	57,876	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)		201,802		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part A Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,689,484	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	19,699,343	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)	660,239	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)	152.26	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)	5.51	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.79	31.00
32.00	Sum of lines 30 and 31	25.30	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.09	33.00
34.00	Disproportionate share adjustment (see instructions)	539,533	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part A Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

Line	Description	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)	0.000114159	0.000121143	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	731,318	724,129	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	59,944	664,611	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	724,555		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)	23,313,154		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

Line	Description	Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	23,313,154	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,870,724	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)	25,183,878	59.00
60.00	Primary payer payments	712	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	25,183,166	61.00
62.00	Deductibles billed to program beneficiaries	2,265,312	62.00
63.00	Coinsurance billed to program beneficiaries	85,624	63.00
64.00	Allowable bad debts (see instructions)	230,903	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	150,087	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	42,705	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	22,982,317	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)	15,036	70.93
70.94	HRR adjustment amount (see instructions)	-178,034	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part A Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,819,319	71.00
71.01	Sequestration adjustment (see instructions)		456,386	71.01
72.00	Interim payments		22,293,843	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)		69,090	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		318,761	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,902	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,851,185	2.00
3.00	PPS payments	12,652,044	3.00
4.00	Outlier payment (see instructions)	38,216	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)	15,902	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	119,282	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)	119,282	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)	119,282	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	103,380	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)	15,902	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)	12,690,260	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)	2,429,018	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)	10,277,144	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)	10,277,144	30.00
31.00	Primary payer payments	6,052	31.00
32.00	Subtotal (line 30 minus line 31)	10,271,092	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)	260,984	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	169,640	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	145,082	36.00
37.00	Subtotal (see instructions)	10,440,732	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-137	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	10,440,869	40.00
40.01	Sequestration adjustment (see instructions)	208,817	40.01
41.00	Interim payments	10,407,437	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-175,385	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	738	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,060	2.00
3.00	PPS payments	1,480	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	738	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,517	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)	5,517	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)	5,517	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,779	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)	738	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)	1,480	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)	106	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,112	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,112	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,112	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,112	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,112	40.00
40.01	Sequestration adjustment (see instructions)	42	40.01
41.00	Interim payments	2,427	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-357	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	217	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	170	2.00
3.00	PPS payments	257	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	217	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,624	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)	1,624	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)	1,624	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,407	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)	217	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)	257	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	474	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)	474	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	474	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	474	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	474	40.00
40.01	Sequestration adjustment (see instructions)	9	40.01
41.00	Interim payments	570	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-105	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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 1/27/2018 2:15 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,293,843		10,380,437	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	03/06/2017	27,000	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		27,000	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)		22,293,843		10,407,437	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		69,090		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		175,385	6.02
7.00	Total Medicare program liability (see instructions)		22,362,933		10,232,052	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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-1 Part I Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	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		1,092,645		2,427	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)		1,092,645		2,427	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		17,771		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		357	6.02
7.00	Total Medicare program liability (see instructions)		1,110,416		2,070	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-1 Part I Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IRF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,953,664		570	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)		1,953,664		570	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		7,946		105	6.02
7.00	Total Medicare program liability (see instructions)		1,945,718		465	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: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-1 Part II Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	5,254	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	10,884	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,663	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	19,745	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	698,069,350	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	22,151,941	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)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part II Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,296,893	1.00
2.00	Net IPF PPS Outlier Payments	100	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	18.178082	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,296,993	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,296,993	16.00
17.00	Primary payer payments	8,329	17.00
18.00	Subtotal (line 16 less line 17).	1,288,664	18.00
19.00	Deductibles	145,068	19.00
20.00	Subtotal (line 18 minus line 19)	1,143,596	20.00
21.00	Coinsurance	28,644	21.00
22.00	Subtotal (line 20 minus line 21)	1,114,952	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,886	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	18,126	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,998	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,133,078	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,133,078	31.00
31.01	Sequestration adjustment (see instructions)	22,662	31.01
32.00	Interim payments	1,092,645	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	17,771	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	100	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part III Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,631,722	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0406	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	80,770	3.00
4.00	Outlier Payments	290,973	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)	4.876712	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)	2,003,465	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)	2,003,465	17.00
18.00	Primary payer payments	10,800	18.00
19.00	Subtotal (line 17 less line 18).	1,992,665	19.00
20.00	Deductibles	5,264	20.00
21.00	Subtotal (line 19 minus line 20)	1,987,401	21.00
22.00	Coinsurance	1,974	22.00
23.00	Subtotal (line 21 minus line 22)	1,985,427	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)	1,985,427	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)	1,985,427	32.00
32.01	Sequestration adjustment (see instructions)	39,709	32.01
33.00	Interim payments	1,953,664	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)	-7,946	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	290,973	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: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	6,958,220		1.00
2.00	Medical and other services		8,429,367	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,958,220	8,429,367	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)	6,958,220	8,429,367	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	40,136,414	72,992,384	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)	40,136,414	72,992,384	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)	40,136,414	72,992,384	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	33,178,194	64,563,017	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)	6,958,220	8,429,367	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)	6,958,220	8,429,367	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)	6,958,220	8,429,367	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)	6,958,220	8,429,367	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	6,958,220	8,429,367	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)	6,958,220	8,429,367	40.00
41.00	Interim payments	8,786,480	5,326,768	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-1,828,260	3,102,599	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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 1/27/2018 2:15 pm

Title XIX | Subprovider - IPF | 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	2,289,421		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)	2,289,421	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)	2,289,421	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	3,684,683	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)	3,684,683	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)	3,684,683	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,395,262	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)	2,289,421	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)	2,289,421	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)	2,289,421	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)	2,289,421	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,289,421	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)	2,289,421	0	40.00
41.00	Interim payments	2,479,251	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-189,830	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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 1/27/2018 2:15 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	199,095		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)	199,095	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)	199,095	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	201,802	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)	201,802	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)	201,802	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,707	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)	199,095	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)	199,095	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)	199,095	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)	199,095	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	199,095	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)	199,095	0	40.00
41.00	Interim payments	81,432	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	117,663	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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G | Date/Time Prepared: 1/27/2018 2:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,571	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	29,416,470	0	0	0	4.00
5.00	Other receivable	7,986	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,947,330	0	0	0	6.00
7.00	Inventory	6,140,266	0	0	0	7.00
8.00	Prepaid expenses	769,930	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-9,355	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,390,538	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,262,718	0	0	0	12.00
13.00	Land improvements	3,158,371	0	0	0	13.00
14.00	Accumulated depreciation	-3,038,794	0	0	0	14.00
15.00	Buildings	38,638,215	0	0	0	15.00
16.00	Accumulated depreciation	-25,807,069	0	0	0	16.00
17.00	Leasehold improvements	8,056,095	0	0	0	17.00
18.00	Accumulated depreciation	-5,851,048	0	0	0	18.00
19.00	Fixed equipment	27,079,070	0	0	0	19.00
20.00	Accumulated depreciation	-19,695,434	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	41,671,474	0	0	0	23.00
24.00	Accumulated depreciation	-31,439,116	0	0	0	24.00
25.00	Minor equipment depreciable	4,685,379	0	0	0	25.00
26.00	Accumulated depreciation	-3,121,955	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	4,519,661	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	40,117,567	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,063,197	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,386,484	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,449,681	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,957,786	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,463,024	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,856,055	0	0	0	38.00
39.00	Payroll taxes payable	1,772,246	0	0	0	39.00
40.00	Notes and loans payable (short term)	165,123	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	396	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,256,844	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	445,743	0	0	0	47.00
48.00	Unsecured loans	-214,085,355	0	0	0	48.00
49.00	Other long term liabilities	59,815	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-213,579,797	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-203,322,953	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	275,280,739				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	275,280,739	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,957,786	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-1 | Date/Time Prepared: 1/27/2018 2:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		268,942,469		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,255,954				2.00
3.00	Total (sum of line 1 and line 2)		278,198,423		0		3.00
4.00	ROUNDING	33		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)		33		0		10.00
11.00	Subtotal (line 3 plus line 10)		278,198,456		0		11.00
12.00	FEDERAL TAX LIABILITY	2,917,717		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)		2,917,717		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		275,280,739		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	ROUNDING		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	FEDERAL TAX LIABILITY		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: 15-0046 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/27/2018 2:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,078,143		18,078,143	1.00
2.00	SUBPROVIDER - IPF	25,189,381		25,189,381	2.00
3.00	SUBPROVIDER - IRF	2,310,130		2,310,130	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	45,577,654		45,577,654	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,165,538		9,165,538	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)	9,165,538		9,165,538	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	54,743,192		54,743,192	17.00
18.00	Ancillary services	268,449,427	316,146,151	584,595,578	18.00
19.00	Outpatient services	16,443,558	42,804,535	59,248,093	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	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)	339,636,177	358,950,686	698,586,863	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		118,251,213		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ROUNDING	15			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)		15		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	GAIN/LOSS ON DISPOSALS	7,797			38.00
39.00	INTEREST INCOME	14,855			39.00
40.00	UNCLAIMED PROPERTY	4,587			40.00
41.00	HITECH	1,983			41.00
42.00	Total deductions (sum of lines 37-41)		29,222		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		118,222,006		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet G-3 Date/Time Prepared: 1/27/2018 2:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	698,586,863	1.00
2.00	Less contractual allowances and discounts on patients' accounts	571,489,502	2.00
3.00	Net patient revenues (line 1 minus line 2)	127,097,361	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	118,222,006	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,875,355	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	380,599	24.00
25.00	Total other income (sum of lines 6-24)	380,599	25.00
26.00	Total (line 5 plus line 25)	9,255,954	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,255,954	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0046	Period: From 09/01/2016 To 08/31/2017	Worksheet L Parts I-III Date/Time Prepared: 1/27/2018 2:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,719,942	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	60,485	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)	54.33	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)	5.51	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.79	8.00
9.00	Sum of lines 7 and 8	25.30	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.25	10.00
11.00	Disproportionate share adjustment (see instructions)	90,297	11.00
12.00	Total prospective capital payments (see instructions)	1,870,724	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