Health Financial Systems | HEART HOSPITAL AT DEACONESS GATEWAY | In Lieu of Form CMS-2552-10

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: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 4:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 4:01 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEART HOSPITAL AT DEACONESS GATEWAY (15-0175) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 2/26/2018 Time: 4:01 pm
uJ0dHVaYDJu1tX9yFQwScXBUfZ2mC0
88CNGOFuEt6Dsd3nsOmZAbbTtmvOgg
NKqNO9WlFHOtVZHm

PI: Date: 2/26/2018 Time: 4:01 pm
Fn6kDGJSZr4ztx8NnitKpWq18jZuP0
HF4oaOfoe9O1jBnTkSEEl7LraFAaiM
u1aZONYF.CO9lTMD

(Signed) Rebecca L. Malotte
Officer or Administrator of Provider(s)

Executive Director & CNO
Title

February 27, 2018
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	30,753	52,952	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	30,753	52,952	0	0	200.00

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

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

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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: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 4:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 4:01 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEART HOSPITAL AT DEACONESS GATEWAY (15-0175) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	30,753	52,952	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	30,753	52,952	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 3:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4007 GATEWAY BOULEVARD	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630-	County: WARRICK	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	HEART HOSPITAL AT DEACONESS GATEWAY	150175	21780	1	02/23/2009	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 3:42 pm

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

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		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
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. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 3:42 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital 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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 3:42 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	44,314	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 3:42 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: DEACONESS HEALTH SYSTEM, INC	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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.	N		146.00

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2017	12/29/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 3:42 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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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	01/31/2018	Y	01/31/2018	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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 3:42 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	DANIELLE	METZGER-CUNDIFF	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 3:42 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 ANALYST		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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2018 3:42 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	24	8,760	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)		24	8,760	0.00	0	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)		24	8,760	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 3:42 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)	3,269	48	5,958			1.00
2.00	HMO and other (see instructions)	733	209				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,269	48	5,958			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)	3,269	48	5,958	0.00	156.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	156.40	27.00
28.00	Observation Bed Days		46	598			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 3:42 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	802	15	1,495	1.00
2.00	HMO and other (see instructions)			160	50		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	802	15	1,495	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 3:42 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	9,077,352	1,169,922	10,247,274	328,235.00	31.22	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)		1,013	0	1,013	50.00	20.26	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,236,928	0	1,236,928	13,967.00	88.56	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		179,535	0	179,535	889.00	201.95	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		2,079,801	0	2,079,801	71,453.00	29.11	14.01
14.02	Related organization salaries		94,341	0	94,341	3,102.00	30.41	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)		3,152,800	0	3,152,800			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		22,147	0	22,147			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	991,229	-21,635	969,594	21,559.00	44.97	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 3:42 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		333,889	0	333,889	1,478.00	225.91	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		146,675	0	146,675	8,246.00	17.79	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		125,675	0	125,675	6,891.00	18.24	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	207,080	595	207,675	4,705.00	44.14	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	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	27,954	0	27,954	799.00	34.99	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/26/2018 3:42 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)		9,683,591	1,169,922	10,853,513	344,850.00	31.47	1.00
2.00	Excluded area salaries (see instructions)		1,013	0	1,013	50.00	20.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,682,578	1,169,922	10,852,500	344,800.00	31.47	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,590,605	0	3,590,605	89,411.00	40.16	4.00
5.00	Subtotal wage-related costs (see inst.)		3,152,800	0	3,152,800	0.00	29.05	5.00
6.00	Total (sum of lines 3 thru 5)		16,425,983	1,169,922	17,595,905	434,211.00	40.52	6.00
7.00	Total overhead cost (see instructions)		1,832,502	-21,040	1,811,462	43,678.00	41.47	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/26/2018 3:42 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	507,907	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)	31,296	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	37	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	495	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)	1,536,065	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	55,136	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	546	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)	127,126	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	6,862	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	759,428	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	304	19.00
20.00	State or Federal Unemployment Taxes	56,377	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	55,147	22.00
23.00	Tuition Reimbursement	38,221	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,174,947	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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 2/26/2018 3:42 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	1,236,928	0	1.00
2.00	Hospital	1,236,928	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet S-10 Date/Time Prepared: 2/26/2018 3:42 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)	0.263165	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,037,192	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 and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	7,990,761	6.00
7.00	Medicaid cost (line 1 times line 6)	2,102,889	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)	1,065,697	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)	1,065,697	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,762,430	539,704	2,302,134	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	463,810	539,704	1,003,514	21.00
22.00	Payments received from patients for amounts previously written off as charity care	43,644	58,134	101,778	22.00
23.00	Cost of charity care (line 21 minus line 22)	420,166	481,570	901,736	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	289,852	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	102,086	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	157,056	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	132,796	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	89,917	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	991,653	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,057,350	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 3:42 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		841	841	1,747,656	1,748,497	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,831,635	2,831,635	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,598,268	2,598,268	-101,042	2,497,226	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	991,229	7,923,808	8,915,037	-2,936,286	5,978,751	5.00
7.00	00700	OPERATION OF PLANT	0	537,604	537,604	0	537,604	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	132,572	132,572	0	132,572	8.00
9.00	00900	HOUSEKEEPING	0	271,629	271,629	0	271,629	9.00
10.00	01000	DIETARY	0	276,502	276,502	0	276,502	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	207,080	65,126	272,206	0	272,206	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	147,541	147,541	-15,779	131,762	14.00
15.00	01500	PHARMACY	0	2,056,584	2,056,584	-1,267,494	789,090	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	609,323	609,323	0	609,323	16.00
17.00	01700	SOCIAL SERVICE	27,954	150,945	178,899	0	178,899	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,330,152	1,974,909	5,305,061	-377,148	4,927,913	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	614	6,345,180	6,345,794	-1,872,377	4,473,417	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	530,213	530,213	0	530,213	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,558,099	11,139,260	13,697,359	-9,048,085	4,649,274	59.00
60.00	06000	LABORATORY	0	1,575,775	1,575,775	-2,813	1,572,962	60.00
64.00	06400	INTRAVENOUS THERAPY	603,920	335,558	939,478	-154,931	784,547	64.00
65.00	06500	RESPIRATORY THERAPY	0	162,962	162,962	-18,333	144,629	65.00
66.00	06600	PHYSICAL THERAPY	0	235,185	235,185	0	235,185	66.00
69.00	06900	ELECTROCARDIOLOGY	840,856	1,114,770	1,955,626	-316,362	1,639,264	69.00
69.01	06901	CARDIAC REHAB	494,608	272,287	766,895	-5,408	761,487	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,327,964	1,327,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,940,146	8,940,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,267,494	1,267,494	73.00
74.00	07400	RENAL DIALYSIS	21,827	26,677	48,504	1,163	49,667	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,076,339	38,483,519	47,559,858	0	47,559,858	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,013	385	1,398	0	1,398	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	17,563	17,563	0	17,563	194.02
194.03	07953	DEACONESS HOSPITAL	0	5,948	5,948	0	5,948	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	9,077,352	38,507,415	47,584,767	0	47,584,767	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 3:42 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	-548,876	1,199,621		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-471	2,831,164		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,409,936	3,907,162		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,494	6,065,245		5.00
7.00	00700	OPERATION OF PLANT	-18,801	518,803		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-58,381	74,191		8.00
9.00	00900	HOUSEKEEPING	-132,341	139,288		9.00
10.00	01000	DIETARY	-245,129	31,373		10.00
11.00	01100	CAFETERIA	42,162	42,162		11.00
13.00	01300	NURSING ADMINISTRATION	0	272,206		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-65,704	66,058		14.00
15.00	01500	PHARMACY	-717,946	71,144		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-372,211	237,112		16.00
17.00	01700	SOCIAL SERVICE	0	178,899		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,927,913		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,547,547	2,925,870		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,101	777,314		54.00
59.00	05900	CARDIAC CATHETERIZATION	-71,971	4,577,303		59.00
60.00	06000	LABORATORY	5,509	1,578,471		60.00
64.00	06400	INTRAVENOUS THERAPY	0	784,547		64.00
65.00	06500	RESPIRATORY THERAPY	490,038	634,667		65.00
66.00	06600	PHYSICAL THERAPY	-132,241	102,944		66.00
69.00	06900	ELECTROCARDIOLOGY	-99,738	1,539,526		69.00
69.01	06901	CARDIAC REHAB	-8,861	752,626		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	304,379	1,632,343		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,940,146		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,267,494		73.00
74.00	07400	RENAL DIALYSIS	-475	49,192		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,435,074	46,124,784		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,398		192.00
194.00	07950	MISC NONREIMBURSABLE	0	0		194.00
194.02	07952	PUBLIC RELATIONS	0	17,563		194.02
194.03	07953	DEACONESS HOSPITAL	0	5,948		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,435,074	46,149,693		200.00

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:42 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,850,581	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	1,850,581	
	B - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,748,497	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	760,106	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	2,508,603	
	C - INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,472	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	29,472	
	D - PROPERTY TAXES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	134,690	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	134,690	
	E - MEDICAL SUPPLIES AND DRUGS CHARGED				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,327,964	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,940,146	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,267,494	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	11,535,604	
	F - PROFESSIONAL FEES				
1.00	CARDIAC CATHETERIZATION	59.00	0	109,750	1.00
2.00	RENAL DIALYSIS	74.00	0	1,163	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,650	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	112,563	
	G - INCENTIVE COMPENSATION				
1.00	CARDIAC CATHETERIZATION	59.00	8,928	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	8,069	0	2.00
3.00	CARDIAC REHAB	69.01	7,559	0	3.00
4.00		0.00	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	2,769	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	48,270	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	25,527	0	7.00
8.00	INTRAVENOUS THERAPY	64.00	6,046	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	9,751	0	9.00
10.00	CARDIAC REHAB	69.01	8,679	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		125,598	0	
	H - DISABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	428	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	15,445	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	12,625	3.00
4.00	INTRAVENOUS THERAPY	64.00	0	342	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	2,007	5.00
6.00	CARDIAC REHAB	69.01	0	1,561	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	32,408	

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:42 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	I - SALARIES IN NON-SALARY ACCOUNTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	580	0		1.00
2.00	NURSING ADMINISTRATION	13.00	595	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	12,430	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	2,950	0		4.00
5.00	INTRAVENOUS THERAPY	64.00	275	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	815	0		6.00
7.00	CARDIAC REHAB	69.01	425	0		7.00
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
	TOTALS		18,070	0		
	J - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	56,786		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	56,786		
	K - DEACONESS SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	301,211	0		1.00
2.00	OPERATING ROOM	50.00	719,209	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	16,275	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	22,638	0		4.00
5.00	CARDIAC REHAB	69.01	23,885	0		5.00
	TOTALS		1,083,218	0		
500.00	Grand Total: Increases		1,226,886	16,260,707		500.00

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EQUIPMENT DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	841	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	76,848	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	425,418	0		4.00
5.00	OPERATING ROOM	50.00	0	112,934	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	864,371	0		6.00
7.00	INTRAVENOUS THERAPY	64.00	0	14,341	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	334,182	0		8.00
9.00	CARDIAC REHAB	69.01	0	21,646	0		9.00
	TOTALS		0	1,850,581			
	B - LEASES						
1.00		0.00	0	0	10		1.00
2.00		0.00	0	0	10		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,508,603	0		3.00
	TOTALS		0	2,508,603			
	C - INSURANCE						
1.00		0.00	0	0	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	29,472	0		2.00
	TOTALS		0	29,472			
	D - PROPERTY TAXES						
1.00		0.00	0	0	13		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	134,690	0		2.00
	TOTALS		0	134,690			
	E - MEDICAL SUPPLIES AND DRUGS CHARGED						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,779	0		4.00
5.00	PHARMACY	15.00	0	1,267,494	0		5.00
6.00	OPERATING ROOM	50.00	0	1,759,443	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	8,327,919	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	146,636	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	18,333	0		9.00
	TOTALS		0	11,535,604			
	F - PROFESSIONAL FEES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	109,750	0		4.00
5.00	LABORATORY	60.00	0	2,813	0		5.00
	TOTALS		0	112,563			
	G - INCENTIVE COMPENSATION						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	24,556	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	101,042	0		11.00
	TOTALS		24,556	101,042			
	H - DISABILITY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	428	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	15,445	0	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	12,625	0	0		9.00
10.00	INTRAVENOUS THERAPY	64.00	342	0	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	2,007	0	0		11.00
12.00	CARDIAC REHAB	69.01	1,561	0	0		12.00
	TOTALS		32,408	0			
	I - SALARIES IN NON-SALARY ACCOUNTS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:42 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	580	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	595	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	12,430	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	2,950	0		12.00
13.00	INTRAVENOUS THERAPY	64.00	0	275	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	815	0		14.00
15.00	CARDIAC REHAB	69.01	0	425	0		15.00
	TOTALS		0	18,070			
	J - INTEREST EXPENSE						
1.00		0.00	0	0	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	56,786	0		2.00
	TOTALS		0	56,786			
	K - DEACONESS SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	0	301,211	0		1.00
2.00	OPERATING ROOM	50.00	0	719,209	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	16,275	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	22,638	0		4.00
5.00	CARDIAC REHAB	69.01	0	23,885	0		5.00
	TOTALS		0	1,083,218			
500.00	Grand Total: Decreases		56,964	17,430,629			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 3:42 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,633,894	783,512	0	783,512	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,633,894	783,512	0	783,512	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,633,894	783,512	0	783,512	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,417,406	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,417,406	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,417,406	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 3:42 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	841	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	841	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	841		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	841		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2018 3:42 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,417,406	0	15,417,406	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	15,417,406	0	15,417,406	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,199,621	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,850,581	760,106	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,850,581	1,959,727	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,199,621	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56,315	29,472	134,690	0	2,831,164	2.00
3.00	Total (sum of lines 1-2)	56,315	29,472	134,690	0	4,030,785	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 3:42 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)	B	-471	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,762	ADMINISTRATIVE & GENERAL	5.00	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	-185,306			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	26,717			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 and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	RESEARCH	A	-382,435	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 3:42 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	
34.00	HAF	A	-891,817	ADMINISTRATIVE & GENERAL	5.00	0	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,435,074				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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 3:42 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING LEASE	1,199,621	1,748,497	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	LEASES	760,106	760,106	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES	150	72,608	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	CONTRACTED SERVICES	74,191	132,572	4.00
4.01	13.00	NURSING ADMINISTRATION	CONTRACTED SERVICES	36,357	36,357	4.01
4.02	17.00	SOCIAL SERVICE	CONTRACTED SERVICES	136,116	136,116	4.02
4.03	30.00	ADULTS & PEDIATRICS	CONTRACTED SERVICES	339,859	339,859	4.03
4.04	50.00	OPERATING ROOM	CONTRACTED SERVICES	773,259	2,320,806	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	CONTRACTED SERVICES	558,428	311,327	4.05
4.06	59.00	CARDIAC CATHETERIZATION	CONTRACTED SERVICES	-266,919	-266,919	4.06
4.07	60.00	LABORATORY	CONTRACTED SERVICES	1,573,456	1,567,947	4.07
4.08	64.00	INTRAVENOUS THERAPY	CONTRACTED SERVICES	22,638	22,638	4.08
4.09	65.00	RESPIRATORY THERAPY	CONTRACTED SERVICES	620,013	129,975	4.09
4.10	69.00	ELECTROCARDIOLOGY	CONTRACTED SERVICES	66,313	66,313	4.10
4.11	69.01	CARDIAC REHAB	CONTRACTED SERVICES	-8,910	-8,910	4.11
4.12	71.00	MEDICAL SUPPLIES CHARGED TO	CONTRACTED SERVICES	304,379	0	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES	1,470,930	60,994	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES	3,817,499	2,378,272	4.14
4.15	7.00	OPERATION OF PLANT	CONTRACTED SERVICES	222,977	241,778	4.15
4.16	9.00	HOUSEKEEPING	CONTRACTED SERVICES	139,288	271,629	4.16
4.17	10.00	DIETARY	CONTRACTED SERVICES	31,373	276,502	4.17
4.18	11.00	CAFETERIA	CONTRACTED SERVICES	42,162	0	4.18
4.19	14.00	CENTRAL SERVICES & SUPPLY	CONTRACTED SERVICES	65,931	131,635	4.19
4.20	15.00	PHARMACY	CONTRACTED SERVICES	14,135	732,081	4.20
4.21	16.00	MEDICAL RECORDS & LIBRARY	CONTRACTED SERVICES	237,112	609,323	4.21
4.22	66.00	PHYSICAL THERAPY	CONTRACTED SERVICES	102,944	235,185	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,333,408	12,306,691	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 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		51.00	DEACONESS HOSPI	0.00	6.00
7.00	B		51.00	DEACONESS HOSPI	0.00	7.00
8.00	B		51.00	DEACONESS HOSPI	0.00	8.00
9.00	B		51.00	DEACONESS HOSPI	0.00	9.00
10.00	B		51.00	DEACONESS HOSPI	0.00	10.00
10.01	B		51.00	DEACONESS HOSPI	0.00	10.01
10.02	B		51.00	DEACONESS HOSPI	0.00	10.02
10.03	B		51.00	DEACONESS HOSPI	0.00	10.03
10.04	B		51.00	DEACONESS HOSPI	0.00	10.04
10.05	B		51.00	DEACONESS HOSPI	0.00	10.05
10.06	B		51.00	DEACONESS HOSPI	0.00	10.06
10.07	B		51.00	DEACONESS HOSPI	0.00	10.07
10.08	B		51.00	DEACONESS HOSPI	0.00	10.08
10.09	B		51.00	DEACONESS HOSPI	0.00	10.09
10.10	B		51.00	DEACONESS HOSPI	0.00	10.10
10.11	B		51.00	DEACONESS HOSPI	0.00	10.11
10.12	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.12
10.13	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.13
10.14	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.14
10.15	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.15
10.16	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.16

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/26/2018 3:42 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	
10.17	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.17
10.18	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.18
10.19	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.19
10.20	A	DEACONESS HEALT	51.00	DEACONESS HOSPI	0.00	10.20
10.21	A	DEACONESS HOSPI	0.00	PHOI	51.00	10.21
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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 3:42 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	-548,876	10		1.00
2.00	0	10		2.00
3.00	-72,458	0		3.00
4.00	-58,381	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	-1,547,547	0		4.04
4.05	247,101	0		4.05
4.06	0	0		4.06
4.07	5,509	0		4.07
4.08	0	0		4.08
4.09	490,038	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	304,379	0		4.12
4.13	1,409,936	0		4.13
4.14	1,439,227	0		4.14
4.15	-18,801	0		4.15
4.16	-132,341	0		4.16
4.17	-245,129	0		4.17
4.18	42,162	0		4.18
4.19	-65,704	0		4.19
4.20	-717,946	0		4.20
4.21	-372,211	0		4.21
4.22	-132,241	0		4.22
5.00	26,717			5.00

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

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

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

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

6.00	HOSPITAL		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOSPITAL		9.00
10.00	HOSPITAL		10.00
10.01	HOSPITAL		10.01
10.02	HOSPITAL		10.02
10.03	HOSPITAL		10.03
10.04	HOSPITAL		10.04
10.05	HOSPITAL		10.05
10.06	HOSPITAL		10.06
10.07	HOSPITAL		10.07
10.08	HOSPITAL		10.08
10.09	HOSPITAL		10.09
10.10	HOSPITAL		10.10
10.11	HOSPITAL		10.11
10.12	HOSPITAL		10.12
10.13	HOSPITAL		10.13
10.14	HOSPITAL		10.14
10.15	HOSPITAL		10.15
10.16	HOSPITAL		10.16
10.17	HOSPITAL		10.17
10.18	HOSPITAL		10.18
10.19	HOSPITAL		10.19

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/26/2018 3:42 pm

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
10.20	HOSPITAL		10.20
10.21	THERAPY REHAB		10.21
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 3:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	8,650	0	8,650	179,000	51	1.00
2.00	59.00	CARDIAC CATHETERIZATION	109,750	0	109,750	179,000	439	2.00
3.00	69.00	ELECTROCARDIOLOGY	99,738	99,738	0	260,300	0	3.00
4.00	69.01	CARDIAC REHAB	59,973	0	59,973	271,900	391	4.00
5.00	74.00	RENAL DIALYSIS	1,163	0	1,163	179,000	8	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			279,274	99,738	179,536		889	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,389	219	0	0	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	37,779	1,889	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	69.01	CARDIAC REHAB	51,112	2,556	0	0	0	4.00
5.00	74.00	RENAL DIALYSIS	688	34	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			93,968	4,698	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	4,389	4,261	4,261		1.00
2.00	59.00	CARDIAC CATHETERIZATION	0	37,779	71,971	71,971		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	99,738		3.00
4.00	69.01	CARDIAC REHAB	0	51,112	8,861	8,861		4.00
5.00	74.00	RENAL DIALYSIS	0	688	475	475		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	93,968	85,568	185,306		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 3:42 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	1,199,621	1,199,621				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,831,164		2,831,164			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,907,162	0	0	3,907,162		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,065,245	9,795	907,929	369,695	7,352,664	5.00
7.00	00700	OPERATION OF PLANT	518,803	15,744	0	0	534,547	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,191	0	0	0	74,191	8.00
9.00	00900	HOUSEKEEPING	139,288	6,198	0	0	145,486	9.00
10.00	01000	DIETARY	31,373	0	0	0	31,373	10.00
11.00	01100	CAFETERIA	42,162	0	0	0	42,162	11.00
13.00	01300	NURSING ADMINISTRATION	272,206	0	0	79,184	351,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,058	0	0	0	66,058	14.00
15.00	01500	PHARMACY	71,144	0	0	0	71,144	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237,112	0	0	0	237,112	16.00
17.00	01700	SOCIAL SERVICE	178,899	0	0	10,659	189,558	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,927,913	492,678	461,494	1,401,850	7,283,935	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,925,870	160,336	122,511	274,460	3,483,177	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	777,314	0	0	0	777,314	54.00
59.00	05900	CARDIAC CATHETERIZATION	4,577,303	363,311	937,670	991,026	6,869,310	59.00
60.00	06000	LABORATORY	1,578,471	0	0	0	1,578,471	60.00
64.00	06400	INTRAVENOUS THERAPY	784,547	0	15,557	241,179	1,041,283	64.00
65.00	06500	RESPIRATORY THERAPY	634,667	0	0	0	634,667	65.00
66.00	06600	PHYSICAL THERAPY	102,944	0	0	0	102,944	66.00
69.00	06900	ELECTROCARDIOLOGY	1,539,526	151,559	362,521	326,948	2,380,554	69.00
69.01	06901	CARDIAC REHAB	752,626	0	23,482	203,453	979,561	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,632,343	0	0	0	1,632,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,940,146	0	0	0	8,940,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,267,494	0	0	0	1,267,494	73.00
74.00	07400	RENAL DIALYSIS	49,192	0	0	8,322	57,514	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,124,784	1,199,621	2,831,164	3,906,776	46,124,398	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,398	0	0	386	1,784	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	17,563	0	0	0	17,563	194.02
194.03	07953	DEACONESS HOSPITAL	5,948	0	0	0	5,948	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,149,693	1,199,621	2,831,164	3,907,162	46,149,693	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 3:42 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	7,352,664					5.00
7.00	00700	OPERATION OF PLANT	101,305	635,852				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,060	0	88,251			8.00
9.00	00900	HOUSEKEEPING	27,572	3,357	0	176,415		9.00
10.00	01000	DIETARY	5,946	0	0	0	37,319	10.00
11.00	01100	CAFETERIA	7,990	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	66,594	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,519	0	0	0	0	14.00
15.00	01500	PHARMACY	13,483	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,937	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	35,924	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,380,422	266,822	49,520	74,421	36,736	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	660,118	86,833	2,670	24,220	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,313	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,301,844	196,760	28,285	54,880	583	59.00
60.00	06000	LABORATORY	299,146	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	197,340	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	120,280	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	19,510	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	451,153	82,080	7,776	22,894	0	69.00
69.01	06901	CARDIAC REHAB	185,642	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,355	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,694,308	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	240,210	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,900	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,347,871	635,852	88,251	176,415	37,319	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	338	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	3,328	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	1,127	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,352,664	635,852	88,251	176,415	37,319	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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	50,152					11.00
13.00	01300	NURSING ADMINISTRATION	756	418,740				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	78,577			14.00
15.00	01500	PHARMACY	0	0	200	84,827		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	282,049	16.00
17.00	01700	SOCIAL SERVICE	137	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,191	188,638	1,569	0	21,856	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,813	32,366	9,262	0	37,562	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,181	0	18,022	54.00
59.00	05900	CARDIAC CATHETERIZATION	11,885	100,998	7,068	0	97,444	59.00
60.00	06000	LABORATORY	0	0	0	0	9,665	60.00
64.00	06400	INTRAVENOUS THERAPY	2,954	25,102	463	0	3,439	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	88	0	7,480	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,428	66.00
69.00	06900	ELECTROCARDIOLOGY	4,672	39,753	593	0	24,719	69.00
69.01	06901	CARDIAC REHAB	3,641	31,059	25	0	6,348	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,518	0	5,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	50,610	0	30,065	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,827	17,121	73.00
74.00	07400	RENAL DIALYSIS	103	824	0	0	422	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,152	418,740	78,577	84,827	282,049	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	50,152	418,740	78,577	84,827	282,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	225,619					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	222,096	9,548,206	0	9,548,206		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,340,021	0	4,340,021		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	943,830	0	943,830		54.00
59.00	05900	CARDIAC CATHETERIZATION	3,523	8,672,580	0	8,672,580		59.00
60.00	06000	LABORATORY	0	1,887,282	0	1,887,282		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,270,581	0	1,270,581		64.00
65.00	06500	RESPIRATORY THERAPY	0	762,515	0	762,515		65.00
66.00	06600	PHYSICAL THERAPY	0	124,882	0	124,882		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,014,194	0	3,014,194		69.00
69.01	06901	CARDIAC REHAB	0	1,206,276	0	1,206,276		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,954,694	0	1,954,694		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,715,129	0	10,715,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,609,652	0	1,609,652		73.00
74.00	07400	RENAL DIALYSIS	0	69,763	0	69,763		74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	225,619	46,119,605	0	46,119,605		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,122	0	2,122		192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0		194.00
194.02	07952	PUBLIC RELATIONS	0	20,891	0	20,891		194.02
194.03	07953	DEACONESS HOSPITAL	0	7,075	0	7,075		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	225,619	46,149,693	0	46,149,693		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	9,795	907,929	917,724	0	5.00
7.00	00700	OPERATION OF PLANT	0	15,744	0	15,744	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,198	0	6,198	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	492,678	461,494	954,172	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	160,336	122,511	282,847	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	363,311	937,670	1,300,981	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	15,557	15,557	0	64.00
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	151,559	362,521	514,080	0	69.00
69.01	06901	CARDIAC REHAB	0	0	23,482	23,482	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,199,621	2,831,164	4,030,785	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,199,621	2,831,164	4,030,785	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:42 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	917,724					5.00
7.00	00700	OPERATION OF PLANT	12,644	28,388				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,755	0	1,755			8.00
9.00	00900	HOUSEKEEPING	3,441	150	0	9,789		9.00
10.00	01000	DIETARY	742	0	0	0	742	10.00
11.00	01100	CAFETERIA	997	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,312	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,563	0	0	0	0	14.00
15.00	01500	PHARMACY	1,683	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,609	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,484	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	172,294	11,912	984	4,130	730	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,391	3,877	53	1,344	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,387	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	162,487	8,784	563	3,045	12	59.00
60.00	06000	LABORATORY	37,337	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	24,631	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,012	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,435	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	56,310	3,665	155	1,270	0	69.00
69.01	06901	CARDIAC REHAB	23,171	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,611	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	211,489	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,981	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,360	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	917,126	28,388	1,755	9,789	742	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	415	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	141	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	917,724	28,388	1,755	9,789	742	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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	997					11.00
13.00	01300	NURSING ADMINISTRATION	15	8,327				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,563			14.00
15.00	01500	PHARMACY	0	0	4	1,687		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	5,609	16.00
17.00	01700	SOCIAL SERVICE	3	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	441	3,751	31	0	435	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76	644	185	0	747	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	24	0	358	54.00
59.00	05900	CARDIAC CATHETERIZATION	236	2,008	141	0	1,938	59.00
60.00	06000	LABORATORY	0	0	0	0	192	60.00
64.00	06400	INTRAVENOUS THERAPY	59	499	9	0	68	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2	0	149	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	48	66.00
69.00	06900	ELECTROCARDIOLOGY	93	791	12	0	492	69.00
69.01	06901	CARDIAC REHAB	72	618	1	0	126	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	150	0	109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,004	0	598	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,687	341	73.00
74.00	07400	RENAL DIALYSIS	2	16	0	0	8	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	997	8,327	1,563	1,687	5,609	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	997	8,327	1,563	1,687	5,609	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,487					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,417	1,153,297	0	1,153,297		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	372,164	0	372,164		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,769	0	18,769		54.00
59.00	05900	CARDIAC CATHETERIZATION	70	1,480,265	0	1,480,265		59.00
60.00	06000	LABORATORY	0	37,529	0	37,529		60.00
64.00	06400	INTRAVENOUS THERAPY	0	40,823	0	40,823		64.00
65.00	06500	RESPIRATORY THERAPY	0	15,163	0	15,163		65.00
66.00	06600	PHYSICAL THERAPY	0	2,483	0	2,483		66.00
69.00	06900	ELECTROCARDIOLOGY	0	576,868	0	576,868		69.00
69.01	06901	CARDIAC REHAB	0	47,470	0	47,470		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,870	0	38,870		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	213,091	0	213,091		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,009	0	32,009		73.00
74.00	07400	RENAL DIALYSIS	0	1,386	0	1,386		74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,487	4,030,187	0	4,030,187		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	42	0	42		192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0		194.00
194.02	07952	PUBLIC RELATIONS	0	415	0	415		194.02
194.03	07953	DEACONESS HOSPITAL	0	141	0	141		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,487	4,030,785	0	4,030,785		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	53,032					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,609,846				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,247,274			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	433	836,954	969,594	-7,352,664	38,797,029	5.00
7.00	00700	OPERATION OF PLANT	696	0	0	0	534,547	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	74,191	8.00
9.00	00900	HOUSEKEEPING	274	0	0	0	145,486	9.00
10.00	01000	DIETARY	0	0	0	0	31,373	10.00
11.00	01100	CAFETERIA	0	0	0	0	42,162	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	207,675	0	351,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	66,058	14.00
15.00	01500	PHARMACY	0	0	0	0	71,144	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	237,112	16.00
17.00	01700	SOCIAL SERVICE	0	0	27,954	0	189,558	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,780	425,418	3,676,618	0	7,283,935	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,088	112,934	719,823	0	3,483,177	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	777,314	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,061	864,371	2,599,154	0	6,869,310	59.00
60.00	06000	LABORATORY	0	0	0	0	1,578,471	60.00
64.00	06400	INTRAVENOUS THERAPY	0	14,341	632,537	0	1,041,283	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	634,667	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	102,944	66.00
69.00	06900	ELECTROCARDIOLOGY	6,700	334,182	857,484	0	2,380,554	69.00
69.01	06901	CARDIAC REHAB	0	21,646	533,595	0	979,561	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,632,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,940,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,267,494	73.00
74.00	07400	RENAL DIALYSIS	0	0	21,827	0	57,514	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,032	2,609,846	10,246,261	-7,352,664	38,771,734	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,013	0	1,784	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	0	0	0	17,563	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	5,948	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,199,621	2,831,164	3,907,162		7,352,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.620701	1.084801	0.381288		0.189516	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		917,724	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.023654	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES - A)	
			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	51,903					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	194,060				8.00
9.00	00900	HOUSEKEEPING	274	0	51,629			9.00
10.00	01000	DIETARY	0	0	0	20,436		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,460	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	22	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	4	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,780	108,892	21,780	20,117	646	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,088	5,872	7,088	0	111	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,061	62,198	16,061	319	346	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	86	64.00
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	6,700	17,098	6,700	0	136	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	106	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,903	194,060	51,629	20,436	1,460	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	635,852	88,251	176,415	37,319	50,152	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.250775	0.454761	3.416975	1.826140	34.350685	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,388	1,755	9,789	742	997	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.546943	0.009044	0.189603	0.036308	0.682877	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:42 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		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	298,448					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,880,140				14.00
15.00	01500	PHARMACY	0	35,396	1,267,494			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	175,249,527		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	6,660	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,448	277,139	0	13,583,740	6,556	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,068	1,636,084	0	23,344,888	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	208,592	0	11,200,841	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	71,984	1,248,471	0	60,516,162	104	59.00
60.00	06000	LABORATORY	0	0	0	6,006,544	0	60.00
64.00	06400	INTRAVENOUS THERAPY	17,891	81,705	0	2,137,509	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,458	0	4,648,564	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,508,968	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,333	104,744	0	15,363,252	0	69.00
69.01	06901	CARDIAC REHAB	22,137	4,441	0	3,945,484	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,327,964	0	3,404,712	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,940,146	0	18,685,504	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,267,494	10,641,081	0	73.00
74.00	07400	RENAL DIALYSIS	587	0	0	262,278	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	298,448	13,880,140	1,267,494	175,249,527	6,660	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	418,740	78,577	84,827	282,049	225,619	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.403058	0.005661	0.066925	0.001609	33.876727	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,327	1,563	1,687	5,609	4,487	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.027901	0.000113	0.001331	0.000032	0.673724	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,548,206		9,548,206	0	9,548,206	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,340,021		4,340,021	0	4,340,021	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,830		943,830	0	943,830	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,672,580		8,672,580	71,971	8,744,551	59.00
60.00	06000	LABORATORY	1,887,282		1,887,282	0	1,887,282	60.00
64.00	06400	INTRAVENOUS THERAPY	1,270,581		1,270,581	0	1,270,581	64.00
65.00	06500	RESPIRATORY THERAPY	762,515	0	762,515	0	762,515	65.00
66.00	06600	PHYSICAL THERAPY	124,882	0	124,882	0	124,882	66.00
69.00	06900	ELECTROCARDIOLOGY	3,014,194		3,014,194	0	3,014,194	69.00
69.01	06901	CARDIAC REHAB	1,206,276		1,206,276	8,861	1,215,137	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,954,694		1,954,694	0	1,954,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,715,129		10,715,129	0	10,715,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,609,652		1,609,652	0	1,609,652	73.00
74.00	07400	RENAL DIALYSIS	69,763		69,763	475	70,238	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	870,933		870,933		870,933	92.00
200.00		Subtotal (see instructions)	46,990,538	0	46,990,538	81,307	47,071,845	200.00
201.00		Less Observation Beds	870,933		870,933		870,933	201.00
202.00		Total (see instructions)	46,119,605	0	46,119,605	81,307	46,200,912	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,622,021		12,622,021			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,411,851	933,037	23,344,888	0.185909	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,351,537	7,849,304	11,200,841	0.084264	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	21,344,979	39,171,183	60,516,162	0.143310	0.000000	59.00
60.00	06000	LABORATORY	5,357,887	648,657	6,006,544	0.314204	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,092,842	44,667	2,137,509	0.594421	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,592,371	56,193	4,648,564	0.164032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,479,747	29,221	1,508,968	0.082760	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,657,409	7,705,843	15,363,252	0.196195	0.000000	69.00
69.01	06901	CARDIAC REHAB	1,350	3,944,134	3,945,484	0.305736	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,748,308	656,404	3,404,712	0.574114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,764,456	11,921,048	18,685,504	0.573446	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,440,282	2,200,799	10,641,081	0.151268	0.000000	73.00
74.00	07400	RENAL DIALYSIS	252,538	9,740	262,278	0.265989	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	179,976	781,743	961,719	0.905600	0.000000	92.00
200.00		Subtotal (see instructions)	99,297,554	75,951,973	175,249,527			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	99,297,554	75,951,973	175,249,527			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.185909	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084264	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144499	59.00
60.00	06000	LABORATORY	0.314204	60.00
64.00	06400	INTRAVENOUS THERAPY	0.594421	64.00
65.00	06500	RESPIRATORY THERAPY	0.164032	65.00
66.00	06600	PHYSICAL THERAPY	0.082760	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196195	69.00
69.01	06901	CARDIAC REHAB	0.307982	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.574114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151268	73.00
74.00	07400	RENAL DIALYSIS	0.267800	74.00
		OUTPATIENT SERVICE COST CENTERS		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905600	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,548,206		9,548,206	0	9,548,206	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,340,021		4,340,021	0	4,340,021	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,830		943,830	0	943,830	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,672,580		8,672,580	71,971	8,744,551	59.00
60.00	06000	LABORATORY	1,887,282		1,887,282	0	1,887,282	60.00
64.00	06400	INTRAVENOUS THERAPY	1,270,581		1,270,581	0	1,270,581	64.00
65.00	06500	RESPIRATORY THERAPY	762,515	0	762,515	0	762,515	65.00
66.00	06600	PHYSICAL THERAPY	124,882	0	124,882	0	124,882	66.00
69.00	06900	ELECTROCARDIOLOGY	3,014,194		3,014,194	0	3,014,194	69.00
69.01	06901	CARDIAC REHAB	1,206,276		1,206,276	8,861	1,215,137	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,954,694		1,954,694	0	1,954,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,715,129		10,715,129	0	10,715,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,609,652		1,609,652	0	1,609,652	73.00
74.00	07400	RENAL DIALYSIS	69,763		69,763	475	70,238	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	870,933		870,933		870,933	92.00
200.00		Subtotal (see instructions)	46,990,538	0	46,990,538	81,307	47,071,845	200.00
201.00		Less Observation Beds	870,933		870,933		870,933	201.00
202.00		Total (see instructions)	46,119,605	0	46,119,605	81,307	46,200,912	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,622,021		12,622,021			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,411,851	933,037	23,344,888	0.185909	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,351,537	7,849,304	11,200,841	0.084264	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	21,344,979	39,171,183	60,516,162	0.143310	0.000000	59.00
60.00	06000	LABORATORY	5,357,887	648,657	6,006,544	0.314204	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,092,842	44,667	2,137,509	0.594421	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,592,371	56,193	4,648,564	0.164032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,479,747	29,221	1,508,968	0.082760	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,657,409	7,705,843	15,363,252	0.196195	0.000000	69.00
69.01	06901	CARDIAC REHAB	1,350	3,944,134	3,945,484	0.305736	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,748,308	656,404	3,404,712	0.574114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,764,456	11,921,048	18,685,504	0.573446	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,440,282	2,200,799	10,641,081	0.151268	0.000000	73.00
74.00	07400	RENAL DIALYSIS	252,538	9,740	262,278	0.265989	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	179,976	781,743	961,719	0.905600	0.000000	92.00
200.00		Subtotal (see instructions)	99,297,554	75,951,973	175,249,527			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	99,297,554	75,951,973	175,249,527			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.185909		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084264		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144499		59.00
60.00	06000	LABORATORY	0.314204		60.00
64.00	06400	INTRAVENOUS THERAPY	0.594421		64.00
65.00	06500	RESPIRATORY THERAPY	0.164032		65.00
66.00	06600	PHYSICAL THERAPY	0.082760		66.00
69.00	06900	ELECTROCARDIOLOGY	0.196195		69.00
69.01	06901	CARDIAC REHAB	0.307982		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.574114		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573446		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151268		73.00
74.00	07400	RENAL DIALYSIS	0.267800		74.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905600		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,340,021	372,164	3,967,857	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,830	18,769	925,061	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,672,580	1,480,265	7,192,315	0	0	59.00
60.00	06000	LABORATORY	1,887,282	37,529	1,849,753	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,270,581	40,823	1,229,758	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	762,515	15,163	747,352	0	0	65.00
66.00	06600	PHYSICAL THERAPY	124,882	2,483	122,399	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,014,194	576,868	2,437,326	0	0	69.00
69.01	06901	CARDIAC REHAB	1,206,276	47,470	1,158,806	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,954,694	38,870	1,915,824	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,715,129	213,091	10,502,038	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,609,652	32,009	1,577,643	0	0	73.00
74.00	07400	RENAL DIALYSIS	69,763	1,386	68,377	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	870,933	105,197	765,736	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	37,442,332	2,982,087	34,460,245	0	0	200.00
201.00		Less Observation Beds	870,933	105,197	765,736	0	0	201.00
202.00		Total (line 200 minus line 201)	36,571,399	2,876,890	33,694,509	0	0	202.00

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

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,340,021	23,344,888	0.185909		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,830	11,200,841	0.084264		54.00
59.00	05900	CARDIAC CATHETERIZATION	8,672,580	60,516,162	0.143310		59.00
60.00	06000	LABORATORY	1,887,282	6,006,544	0.314204		60.00
64.00	06400	INTRAVENOUS THERAPY	1,270,581	2,137,509	0.594421		64.00
65.00	06500	RESPIRATORY THERAPY	762,515	4,648,564	0.164032		65.00
66.00	06600	PHYSICAL THERAPY	124,882	1,508,968	0.082760		66.00
69.00	06900	ELECTROCARDIOLOGY	3,014,194	15,363,252	0.196195		69.00
69.01	06901	CARDIAC REHAB	1,206,276	3,945,484	0.305736		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,954,694	3,404,712	0.574114		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,715,129	18,685,504	0.573446		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,609,652	10,641,081	0.151268		73.00
74.00	07400	RENAL DIALYSIS	69,763	262,278	0.265989		74.00
		OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	870,933	961,719	0.905600		92.00
200.00		Subtotal (sum of lines 50 thru 199)	37,442,332	162,627,506			200.00
201.00		Less Observation Beds	870,933	0			201.00
202.00		Total (line 200 minus line 201)	36,571,399	162,627,506			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,153,297	0	1,153,297	6,556	175.91	30.00
200.00	Total (lines 30 through 199)	1,153,297		1,153,297	6,556		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	3,269	575,050				30.00
200.00	Total (lines 30 through 199)	3,269	575,050				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 3:42 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	372,164	23,344,888	0.015942	10,181,315	162,311	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,769	11,200,841	0.001676	1,723,666	2,889	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,480,265	60,516,162	0.024461	10,847,664	265,345	59.00
60.00	06000	LABORATORY	37,529	6,006,544	0.006248	2,902,554	18,135	60.00
64.00	06400	INTRAVENOUS THERAPY	40,823	2,137,509	0.019098	108,050	2,064	64.00
65.00	06500	RESPIRATORY THERAPY	15,163	4,648,564	0.003262	2,563,214	8,361	65.00
66.00	06600	PHYSICAL THERAPY	2,483	1,508,968	0.001645	894,434	1,471	66.00
69.00	06900	ELECTROCARDIOLOGY	576,868	15,363,252	0.037549	989,454	37,153	69.00
69.01	06901	CARDIAC REHAB	47,470	3,945,484	0.012031	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,870	3,404,712	0.011417	1,186,329	13,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	213,091	18,685,504	0.011404	3,972,091	45,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,009	10,641,081	0.003008	4,761,137	14,322	73.00
74.00	07400	RENAL DIALYSIS	1,386	262,278	0.005284	168,322	889	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	105,197	961,719	0.109384	130,834	14,311	92.00
200.00		Total (lines 50 through 199)	2,982,087	162,627,506		40,429,064	586,093	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,556	0.00	3,269	30.00
200.00		Total (lines 30 through 199)		0	6,556		3,269	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	23,344,888	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,200,841	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	60,516,162	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	6,006,544	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,137,509	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,648,564	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,508,968	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,363,252	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	3,945,484	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,404,712	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,685,504	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,641,081	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	262,278	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	961,719	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	162,627,506		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	10,181,315	0	356,559	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,723,666	0	1,012,026	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	10,847,664	0	17,198,088	0	59.00
60.00	06000	LABORATORY	0.000000	2,902,554	0	227,927	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	108,050	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,563,214	0	15,962	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	894,434	0	7,146	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	989,454	0	696,283	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	1,852,545	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,186,329	0	186,508	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,972,091	0	5,884,616	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,761,137	0	767,321	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	168,322	0	2,252	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	130,834	0	210,032	0	92.00
200.00		Total (lines 50 through 199)		40,429,064	0	28,417,265	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 3:42 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	0.185909	356,559	0	0	66,288	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084264	1,012,026	0	0	85,277	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143310	17,198,088	0	11,033	2,464,658	59.00
60.00	06000	LABORATORY	0.314204	227,927	0	0	71,616	60.00
64.00	06400	INTRAVENOUS THERAPY	0.594421	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.164032	15,962	0	0	2,618	65.00
66.00	06600	PHYSICAL THERAPY	0.082760	7,146	0	0	591	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196195	696,283	0	611	136,607	69.00
69.01	06901	CARDIAC REHAB	0.305736	1,852,545	0	0	566,390	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.574114	186,508	0	0	107,077	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573446	5,884,616	0	0	3,374,510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151268	767,321	0	36,640	116,071	73.00
74.00	07400	RENAL DIALYSIS	0.265989	2,252	0	0	599	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905600	210,032	0	0	190,205	92.00
200.00		Subtotal (see instructions)		28,417,265	0	48,284	7,182,507	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		28,417,265	0	48,284	7,182,507	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,581		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	120		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,542		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	7,243		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	7,243		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,153,297	0	1,153,297	6,556	175.91	30.00
200.00	Total (lines 30 through 199)	1,153,297		1,153,297	6,556		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	48	8,444		30.00
200.00	Total (lines 30 through 199)	48	8,444		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	372,164	23,344,888	0.015942	207,378	3,306	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,769	11,200,841	0.001676	9,802	16	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,480,265	60,516,162	0.024461	296,629	7,256	59.00
60.00	06000	LABORATORY	37,529	6,006,544	0.006248	54,362	340	60.00
64.00	06400	INTRAVENOUS THERAPY	40,823	2,137,509	0.019098	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,163	4,648,564	0.003262	41,266	135	65.00
66.00	06600	PHYSICAL THERAPY	2,483	1,508,968	0.001645	5,747	9	66.00
69.00	06900	ELECTROCARDIOLOGY	576,868	15,363,252	0.037549	14,539	546	69.00
69.01	06901	CARDIAC REHAB	47,470	3,945,484	0.012031	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,870	3,404,712	0.011417	20,161	230	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	213,091	18,685,504	0.011404	54,331	620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,009	10,641,081	0.003008	79,670	240	73.00
74.00	07400	RENAL DIALYSIS	1,386	262,278	0.005284	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	105,197	961,719	0.109384	1,152	126	92.00
200.00		Total (lines 50 through 199)	2,982,087	162,627,506		785,037	12,824	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,556	0.00	48	30.00
200.00		Total (lines 30 through 199)		0	6,556		48	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	23,344,888	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,200,841	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	60,516,162	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	6,006,544	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,137,509	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,648,564	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,508,968	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,363,252	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	3,945,484	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,404,712	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,685,504	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,641,081	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	262,278	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	961,719	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	162,627,506		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	207,378	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	9,802	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	296,629	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	54,362	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	41,266	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,747	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,539	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	20,161	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	54,331	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	79,670	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,152	0	0	0	92.00
200.00		Total (lines 50 through 199)		785,037	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.185909	0	0	3,341	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084264	0	0	34,194	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143310	0	0	601,469	0	59.00
60.00	06000	LABORATORY	0.314204	0	0	12,331	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.594421	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.164032	0	0	6,038	0	65.00
66.00	06600	PHYSICAL THERAPY	0.082760	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196195	0	0	45,092	0	69.00
69.01	06901	CARDIAC REHAB	0.305736	0	0	3,729	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.574114	0	0	5,423	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573446	0	0	167,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151268	0	0	33,201	0	73.00
74.00	07400	RENAL DIALYSIS	0.265989	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905600	0	0	8,334	0	92.00
200.00		Subtotal (see instructions)		0	0	920,341	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	920,341	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	621		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,881		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	86,197		59.00
60.00	06000	LABORATORY	0	3,874		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	990		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,847		69.00
69.01	06901	CARDIAC REHAB	0	1,140		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,113		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,874		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,022		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,547		92.00
200.00		Subtotal (see instructions)	0	216,106		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	216,106		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:42 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)	6,556	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,556	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)	5,958	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)	3,269	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,548,206	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,548,206	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,548,206	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)	1,456.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,761,004	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)	4,761,004	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:42 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	9,112,973	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,873,977	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)	575,050	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	586,093	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,161,143	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,712,834	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)	598	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,456.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	870,933	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,153,297	9,548,206	0.120787	870,933	105,197	90.00
91.00	Nursing School cost	0	9,548,206	0.000000	870,933	0	91.00
92.00	Allied health cost	0	9,548,206	0.000000	870,933	0	92.00
93.00	All other Medical Education	0	9,548,206	0.000000	870,933	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,556	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,556	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)	5,958	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)	48	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,548,206	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,548,206	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,548,206	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)	1,456.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	69,908	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)	69,908	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	165,246	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	235,154	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)	8,444	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,824	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	21,268	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	213,886	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)	598	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,456.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	870,933	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,153,297	9,548,206	0.120787	870,933	105,197	90.00
91.00	Nursing School cost	0	9,548,206	0.000000	870,933	0	91.00
92.00	Allied health cost	0	9,548,206	0.000000	870,933	0	92.00
93.00	All other Medical Education	0	9,548,206	0.000000	870,933	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,085,237		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.185909	10,181,315	1,892,798	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084264	1,723,666	145,243	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144499	10,847,664	1,567,477	59.00
60.00	06000	LABORATORY	0.314204	2,902,554	911,994	60.00
64.00	06400	INTRAVENOUS THERAPY	0.594421	108,050	64,227	64.00
65.00	06500	RESPIRATORY THERAPY	0.164032	2,563,214	420,449	65.00
66.00	06600	PHYSICAL THERAPY	0.082760	894,434	74,023	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196195	989,454	194,126	69.00
69.01	06901	CARDIAC REHAB	0.307982	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.574114	1,186,329	681,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573446	3,972,091	2,277,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151268	4,761,137	720,208	73.00
74.00	07400	RENAL DIALYSIS	0.267800	168,322	45,077	74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905600	130,834	118,483	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,429,064	9,112,973	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)		40,429,064		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		98,402		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.185909	207,378	38,553	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084264	9,802	826	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144499	296,629	42,863	59.00
60.00	06000	LABORATORY	0.314204	54,362	17,081	60.00
64.00	06400	INTRAVENOUS THERAPY	0.594421	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.164032	41,266	6,769	65.00
66.00	06600	PHYSICAL THERAPY	0.082760	5,747	476	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196195	14,539	2,852	69.00
69.01	06901	CARDIAC REHAB	0.307982	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.574114	20,161	11,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573446	54,331	31,156	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151268	79,670	12,052	73.00
74.00	07400	RENAL DIALYSIS	0.267800	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905600	1,152	1,043	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		785,037	165,246	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)		785,037		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 3:42 pm
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		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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,385,489	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)	249,021	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	2,499,892	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	22.36	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		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)	11,634,510		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		11,634,510	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		942,762	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)		12,577,272	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,577,272	61.00
62.00	Deductibles billed to program beneficiaries		754,824	62.00
63.00	Coinsurance billed to program beneficiaries		658	63.00
64.00	Allowable bad debts (see instructions)		48,277	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		31,380	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,806	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,853,170	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		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)		130,737	70.93
70.94	HRR adjustment amount (see instructions)		-11,385	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,972,522	71.00
71.01	Sequestration adjustment (see instructions)		239,450	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		11,702,319	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		30,753	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		22,771	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	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2018 3:42 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,385,489	0		11,385,489	11,385,489	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	249,021	0	0	249,021	249,021	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,499,892	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,634,510	0	0	11,634,510	11,634,510	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,634,510	0	0	11,634,510	11,634,510	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	942,762	0	0	942,762	942,762	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2018 3:42 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	12,577,272	12,577,272	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	914,809	0	0	914,809	914,809	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,953	0	0	27,953	27,953	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	942,762	0	0	942,762	942,762	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.073036		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				918,594	918,594	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 3:42 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,385,489		11,385,489	11,385,489	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	249,021	0	249,021	249,021	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,499,892	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,634,510	0	11,634,510	11,634,510	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,634,510	0	11,634,510	11,634,510	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	942,762	0	942,762	942,762	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	12,577,272	12,577,272	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 3:42 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	914,809	0	914,809	914,809	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,953	0	27,953	27,953	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	942,762	0	942,762	942,762	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	130,737	0	130,737	130,737	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-11,385	0	-11,385	-11,385	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 3:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,243	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,182,507	2.00
3.00	OPPS payments	7,574,335	3.00
4.00	Outlier payment (see instructions)	21,232	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,243	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	48,284	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)	48,284	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)	48,284	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	41,041	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) (see instructions)	7,243	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	7,595,567	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)	974,138	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)	6,628,672	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)	6,628,672	30.00
31.00	Primary payer payments	1,595	31.00
32.00	Subtotal (line 30 minus line 31)	6,627,077	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)	108,779	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	70,706	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	78,727	36.00
37.00	Subtotal (see instructions)	6,697,783	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	21,011	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,697,783	40.00
40.01	Sequestration adjustment (see instructions)	133,956	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,510,875	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	52,952	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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/26/2018 3:42 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,702,319		6,510,875	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)		11,702,319		6,510,875	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		30,753		52,952	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,733,072		6,563,827	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: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 3:42 pm
	Title XVIII	Hospital	PPS

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

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

Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 3:42 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	807,737	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	17,473,608	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,770,181	0	0	0	6.00
7.00	Inventory	1,590,334	0	0	0	7.00
8.00	Prepaid expenses	297,223	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,398,721	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	15,417,406	0	0	0	19.00
20.00	Accumulated depreciation	-8,946,830	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,470,576	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,912,386	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,912,386	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,781,683	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,341,766	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,211,418	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	712,553	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,168,222	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,433,959	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,041,539	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,041,539	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,475,498	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,306,185				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)	18,306,185	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,781,683	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 3:42 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		16,377,610		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,466,083				2.00
3.00	Total (sum of line 1 and line 2)		28,843,693		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,843,693		0		11.00
12.00	DISTRIBUTIONS TO MEMBERS	10,537,505		0		0	12.00
13.00	ROUNDING	3		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)		10,537,508		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,306,185		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DISTRIBUTIONS TO MEMBERS		0		12.00
13.00	ROUNDING		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: 15-0175 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2018 3:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,801,997		12,801,997	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,801,997		12,801,997	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,801,997		12,801,997	17.00
18.00	Ancillary services	78,800,030	67,168,164	145,968,194	18.00
19.00	Outpatient services	0	781,743	781,743	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	91,602,027	67,949,907	159,551,934	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,584,767		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	GROSS UP CREDITS FOR SERVICE TO DH	2,855,245			37.00
38.00	ROUNDING VARIANCE	8			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		2,855,253		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		44,729,514		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prepared: 2/26/2018 3:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	159,551,934	1.00
2.00	Less contractual allowances and discounts on patients' accounts	102,358,925	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,193,009	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,729,514	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,463,495	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	471	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,117	24.00
25.00	Total other income (sum of lines 6-24)	2,588	25.00
26.00	Total (line 5 plus line 25)	12,466,083	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)	12,466,083	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0175	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/26/2018 3:42 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	914,809	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	27,953	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)	16.32	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	942,762	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