

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: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 10/17/2017 3:56 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: 10/17/2017 Time: 3:56 pm

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,262,816	307,824	0	-1,820,110	1.00
2.00 Subprovider - IPF	0	6,076	0		-253,320	2.00
3.00 Subprovider - IRF	0	-105,658	1		-184,306	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	1,163,234	307,825	0	-2,257,736	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 10/17/2017 3:54 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN Zip Code: 46402		4.00 County: LAKE				
1.00 Street: 600 GRANT STREET		2.00 City: GARY								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
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	METHODIST HOSPITALS, INC	150002	16974	1	01/01/1966	N	P	0	
4.00	Subprovider - IPF	GERIATRIC PSYCH	15S002	16974	4	01/01/2012	N	P	0	
5.00	Subprovider - IRF	REHABILITATION	15T002	16974	5	01/01/1984	N	P	0	
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA	METHODIST HOME CARE SERVICES	157536	16974		02/12/2002	N	P	0	
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	8,491	10,911	483	738	8,124	89		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.	259	465	0	10	206			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/17/2017 3:54 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						0.00	0.00	61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
64.00	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. 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
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

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	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

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		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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	
165.00	Multi campus Is this hospital part of a Multi campus 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
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/17/2017 3:54 pm	
			Beginning 1.00	Ending 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)		10/02/2015	12/30/2015	170.00
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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part II Date/Time Prepared: 10/17/2017 3:54 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/15/2016			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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.	Y					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.	Y					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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/20/2016	Y	04/20/2016		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: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 10/17/2017 3:54 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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				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.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 10/17/2017 3:54 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.	SENIOR MANAGED		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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	370	135,050	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)		370	135,050	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	33	12,045	0.00	0	8.00
8.01 NEONATAL ICU	31.01	35	12,775	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		438	159,870	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00 SUBPROVIDER - IRF	41.00	39	14,235		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		489				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	35,763	8,491	80,347			1.00
2.00 HMO and other (see instructions)	3,385	20,256				2.00
3.00 HMO IPF Subprovider	0	662				3.00
4.00 HMO IRF Subprovider	0	681				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	35,763	8,491	80,347			7.00
8.00 INTENSIVE CARE UNIT	4,163	0	8,379			8.00
8.01 NEONATAL ICU	0	0	3,028			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	2,874			13.00
14.00 Total (see instructions)	39,926	8,491	94,628	3.00	2,045.03	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	546	184	1,506	0.00	9.22	16.00
17.00 SUBPROVIDER - IRF	7,566	259	10,538	0.00	48.19	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	9,632	1,090	19,911	0.00	24.79	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)				3.00	2,127.23	27.00
28.00 Observation Bed Days		0	17,298			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	89	104			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	6,458	1,188	16,026	1.00
2.00 HMO and other (see instructions)			481	3,638		2.00
3.00 HMO IPF Subprovider				165		3.00
4.00 HMO IRF Subprovider				51		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
8.01 NEONATAL ICU						8.01
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	6,458	1,188	16,026	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	83	17	258	16.00
17.00 SUBPROVIDER - IRF	0.00	0	512	22	732	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
10/17/2017 3:54 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	141,816,584	-461,496	141,355,088	4,424,639.00	31.95
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		210,204	0	210,204	6,240.00	33.69
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		25,158,130	147,852	25,305,982	488,153.00	51.84
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		5,031,287	0	5,031,287	115,791.00	43.45
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		741,128	0	741,128	5,499.00	134.78
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		32,588,749	0	32,588,749		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		4,941,788	0	4,941,788		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related						
25.51	Related organization wage-related						
25.52	Home office: Physician Part A - Administrative - wage-related						
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,561,582	-203,202	1,358,380	36,055.00	37.68
27.00	Administrative & General	5.00	20,785,656	-531,881	20,253,775	656,081.00	30.87

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
10/17/2017 3:54 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	1,935,598	0	1,935,598	8,658.00	223.56	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	3,468,572	-6,571	3,462,001	160,025.00	21.63	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	4,639,858	-3,902	4,635,956	302,418.00	15.33	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	3,084,557	-1,024,835	2,059,722	125,252.00	16.44	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	345,340	991,039	1,336,379	79,932.00	16.72	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	2,539,462	-2,838	2,536,624	59,599.00	42.56	38.00
39.00	Central Services and Supply	545,797	-4,696	541,101	32,226.00	16.79	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	2,004,093	-948	2,003,145	85,398.00	23.46	41.00
42.00	Social Service	70,791	505,798	576,589	19,375.00	29.76	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part III
Date/Time Prepared:
10/17/2017 3:54 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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)	143,541,978	-461,496	143,080,482	4,427,057.00	32.32	1.00
2.00	Excluded area salaries (see instructions)	25,158,130	147,852	25,305,982	488,153.00	51.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)	118,383,848	-609,348	117,774,500	3,938,904.00	29.90	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,772,415	0	5,772,415	121,290.00	47.59	4.00
5.00	Subtotal wage-related costs (see inst.)	32,588,749	0	32,588,749	0.00	27.67	5.00
6.00	Total (sum of lines 3 thru 5)	156,745,012	-609,348	156,135,664	4,060,194.00	38.46	6.00
7.00	Total overhead cost (see instructions)	40,981,306	-282,036	40,699,270	1,565,019.00	26.01	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 10/17/2017 3:54 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,965,665 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			6,684,027 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			13,333,728 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			8.02
8.03	Health Insurance (Purchased)			8.03
9.00	Prescription Drug Plan			1,976,302 9.00
10.00	Dental, Hearing and Vision Plan			1,126,944 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			655,141 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)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,556,446 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			9,757,827 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			165,266 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			309,190 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			37,530,536 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: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 10/17/2017 3:54 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0002 Component CCN: 15-7536		Period: From 01/01/2015 To 12/31/2015		Worksheet S-4 Date/Time Prepared: 10/17/2017 3:54 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	458.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23844			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	3,828	341	143	191	4,503	
22.00	Skilled Nursing Visit Charges	574,200	51,150	21,450	28,800	675,600	
23.00	Physical Therapy Visits	2,892	7	23	174	3,096	
24.00	Physical Therapy Visit Charges	472,976	1,148	3,772	28,536	506,432	
25.00	Occupational Therapy Visits	578	1	0	36	615	
26.00	Occupational Therapy Visit Charges	95,370	165	0	5,940	101,475	
27.00	Speech Pathology Visits	111	0	0	14	125	
28.00	Speech Pathology Visit Charges	19,647	0	0	2,478	22,125	
29.00	Medical Social Service Visits	9	0	0	0	9	
30.00	Medical Social Service Visit Charges	2,390	0	0	0	2,390	
31.00	Home Health Aide Visits	1,226	26	6	26	1,284	
32.00	Home Health Aide Visit Charges	82,343	1,742	402	1,742	86,229	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,644	375	172	441	9,632	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,246,926	54,205	25,624	67,496	1,394,251	
36.00	Total Number of Episodes (standard/non outlier)	469		70	29	568	
37.00	Total Number of Outlier Episodes		11		2	13	
38.00	Total Non-Routine Medical Supply Charges	60,948	8,094	2,681	776	72,499	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 10/17/2017 3:54 pm
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				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)			0.246915	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			92,477,761	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			20,969,200	5.00	
6.00	Medicaid charges			277,470,063	6.00	
7.00	Medicaid cost (line 1 times line 6)			68,511,521	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	35,584,929	1,512,626	37,097,555	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	8,786,453	1,512,626	10,299,079	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	185,365	0	185,365	22.00	
23.00	Cost of charity care (line 21 minus line 22)	8,601,088	1,512,626	10,113,714	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				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)			25,364,626	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,884,639	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,899,444	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			22,465,182	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			6,561,795	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			16,675,509	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			16,675,509	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	0	0	9,145,642	9,145,642	1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,561,582	23,419,293	24,980,875	258,294	25,239,169	4.00
5.01	00550	DATA PROCESSING	4,144,742	10,492,980	14,637,722	-469	14,637,253	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	933,774	2,310,959	3,244,733	-53,655	3,191,078	5.02
5.03	00570	ADMINISTRATIVE	2,056,409	532,300	2,588,709	-1,979	2,586,730	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,045,226	1,750,015	3,795,241	-12,473	3,782,768	5.04
5.05	00590	OTHER A&G	11,035,336	24,113,474	35,148,810	-12,226,602	22,922,208	5.05
5.06	00592	PATIENT TRANSPORTATION	570,169	64,936	635,105	-1,812	633,293	5.06
7.00	00700	OPERATION OF PLANT	3,468,572	6,907,487	10,376,059	4,344,714	14,720,773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,444,372	1,444,372	0	1,444,372	8.00
9.00	00900	HOUSEKEEPING	4,639,858	1,410,769	6,050,627	-12,141	6,038,486	9.00
10.00	01000	DIETARY	3,084,557	3,419,044	6,503,601	-2,329,907	4,173,694	10.00
11.00	01100	CAFETERIA	345,340	44,409	389,749	2,296,083	2,685,832	11.00
13.00	01300	NURSING ADMINISTRATION	2,539,462	477,349	3,016,811	-4,363	3,012,448	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	545,797	1,973,814	2,519,611	-121,734	2,397,877	14.00
15.00	01500	PHARMACY	0	15,802,755	15,802,755	-15,820,806	-18,051	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,004,093	978,652	2,982,745	-948	2,981,797	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	505,798	505,798	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	70,791	21,629	92,420	0	92,420	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	210,204	210,204	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	9,588	9,588	22.00
23.00	02300	PARAMED PROGRAM	373,723	81,394	455,117	136,431	591,548	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,413,317	6,788,127	37,201,444	-801,111	36,400,333	30.00
31.00	03100	INTENSIVE CARE UNIT	6,266,673	1,479,218	7,745,891	-253,737	7,492,154	31.00
31.01	03101	NEONATAL ICU	2,269,754	735,103	3,004,857	-6,043	2,998,814	31.01
40.00	04000	SUBPROVIDER - I PF	649,854	68,198	718,052	28,140	746,192	40.00
41.00	04100	SUBPROVIDER - I RF	3,042,703	481,034	3,523,737	-52,734	3,471,003	41.00
43.00	04300	NURSERY	622,116	272,278	894,394	-44,606	849,788	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,193,664	16,273,018	20,466,682	-12,579,802	7,886,880	50.00
50.01	05001	ENDOSCOPY	1,220,107	2,240,064	3,460,171	-408,923	3,051,248	50.01
51.00	05100	RECOVERY ROOM	948,992	131,935	1,080,927	-17,248	1,063,679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,603,031	536,932	3,139,963	-10,962	3,129,001	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,293,936	2,141,313	4,435,249	-115,195	4,320,054	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,301,433	481,981	1,783,414	-79,001	1,704,413	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	526,441	935,303	1,461,744	-22,426	1,439,318	55.00
56.00	05600	RADIOISOTOPE	495,956	920,636	1,416,592	-217	1,416,375	56.00
57.00	05700	CT SCAN	1,026,854	903,278	1,930,132	-70,718	1,859,414	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	405,574	182,844	588,418	-57,980	530,438	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,001,001	7,423,819	9,424,820	-5,435,767	3,989,053	59.00
60.00	06000	LABORATORY	3,523,121	6,663,137	10,186,258	-11,289	10,174,969	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,166,043	364,138	1,530,181	-9,012	1,521,169	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,370,634	958,334	3,328,968	-163,048	3,165,920	65.00
66.00	06600	PHYSICAL THERAPY	1,378,895	130,582	1,509,477	36,091	1,545,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,071,448	141,942	1,213,390	-2,791	1,210,599	67.00
68.00	06800	SPEECH PATHOLOGY	397,185	46,071	443,256	-335	442,921	68.00
69.00	06900	ELECTROCARDIOLOGY	613,329	279,725	893,054	-1,715	891,339	69.00
69.01	06901	CARDIAC REHAB	376,805	419,178	795,983	-733	795,250	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	866,976	4,760,656	5,627,632	-4,523,125	1,104,507	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,196,173	11,196,173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,785,480	12,785,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	428,980	485,676	914,656	16,585,509	17,500,165	73.00
74.00	07400	RENAL DIALYSIS	0	1,789,207	1,789,207	-1,098	1,788,109	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,264,100	2,448,569	4,712,669	-173,530	4,539,139	90.00
91.00	09100	EMERGENCY	6,566,381	2,746,358	9,312,739	-536,826	8,775,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,836,844	341,889	2,178,733	-10,884	2,167,849	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	122,561,578	158,816,174	281,377,752	1,560,402	282,938,154	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,865	187,990	244,855	-624	244,231	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet A Date/Time Prepared: 10/17/2017 3:54 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	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,908,026	17,024,745	32,932,771	-61,487	32,871,284	192.00
192.01	19201	OTHER NON-REIMBURSABLE	3,126,833	2,916,911	6,043,744	-1,498,291	4,545,453	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	163,282	48,622	211,904	0	211,904	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	141,816,584	178,994,442	320,811,026	0	320,811,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
10/17/2017 3:54 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	-2,830,045	6,315,597	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,239,169	4.00
5.01	00550	DATA PROCESSING	-146,200	14,491,053	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	3,191,078	5.02
5.03	00570	ADMINISTRATIVE	0	2,586,730	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-16,982	3,765,786	5.04
5.05	00590	OTHER A&G	-468,038	22,454,170	5.05
5.06	00592	PATIENT TRANSPORTATION	0	633,293	5.06
7.00	00700	OPERATION OF PLANT	0	14,720,773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,444,372	8.00
9.00	00900	HOUSEKEEPING	-1,285	6,037,201	9.00
10.00	01000	DIETARY	-29,882	4,143,812	10.00
11.00	01100	CAFETERIA	-853,443	1,832,389	11.00
13.00	01300	NURSING ADMINISTRATION	-4,605	3,007,843	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,397,877	14.00
15.00	01500	PHARMACY	0	-18,051	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,499	2,979,298	16.00
17.00	01700	SOCIAL SERVICE	0	505,798	17.00
17.01	01701	STAFF EDUCATION	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	92,420	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	210,204	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	9,588	22.00
23.00	02300	PARAMEDICAL PROGRAM	-391,387	200,161	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-482,253	35,918,080	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,492,154	31.00
31.01	03101	NEONATAL ICU	-546,000	2,452,814	31.01
40.00	04000	SUBPROVIDER - I/PF	0	746,192	40.00
41.00	04100	SUBPROVIDER - I/RF	0	3,471,003	41.00
43.00	04300	NURSERY	0	849,788	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,886,880	50.00
50.01	05001	ENDOSCOPY	0	3,051,248	50.01
51.00	05100	RECOVERY ROOM	0	1,063,679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,129,001	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,928	4,317,126	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	1,704,413	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,439,318	55.00
56.00	05600	RADIOISOTOPE	0	1,416,375	56.00
57.00	05700	CT SCAN	-1,551	1,857,863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	530,438	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,989,053	59.00
60.00	06000	LABORATORY	-38,723	10,136,246	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-143,838	1,377,331	62.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,165,920	65.00
66.00	06600	PHYSICAL THERAPY	0	1,545,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,210,599	67.00
68.00	06800	SPEECH PATHOLOGY	0	442,921	68.00
69.00	06900	ELECTROCARDIOLOGY	0	891,339	69.00
69.01	06901	CARDIAC REHAB	-66,139	729,111	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-12,573	1,091,934	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,196,173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,785,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,500,165	73.00
74.00	07400	RENAL DIALYSIS	0	1,788,109	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-102,493	4,436,646	90.00
91.00	09100	EMERGENCY	0	8,775,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,167,849	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,140,864	276,797,290	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	244,231	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,871,284	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	4,545,453	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet A Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	211,904	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	-6,140,864	314,670,162	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	991,039	1,305,044	1.00
	O		991,039	1,305,044	
B - CLINICAL TRAINING COST					
1.00	PARAMED PROGRAM	23.00	143,536	0	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
	O		143,536	0	
C - SOCIAL WORKERS					
1.00	SOCIAL SERVICE	17.00	505,798	0	1.00
	O		505,798	0	
E - RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	210,204	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	9,588	2.00
	O		0	219,792	
F - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,196,173	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,785,480	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
	O		0	23,981,653	
G - LIGHT DUTY					
1.00	HOUSEKEEPING	9.00	10,763	0	1.00
2.00	DIETARY	10.00	354	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	43,350	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	1,536	0	4.00
5.00	SUBPROVIDER - IPF	40.00	28,140	0	5.00
6.00	SUBPROVIDER - IRF	41.00	11,101	0	6.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
10/17/2017 3:54 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00	OPERATING ROOM	50.00	16,298	0	7.00
8.00	ENDOSCOPY	50.01	977	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	17,580	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	3,894	0	10.00
11.00	PHYSICAL THERAPY	66.00	60,795	0	11.00
12.00	EMERGENCY	91.00	2,544	0	12.00
	O		197,332	0	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,827,594	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
	O		0	3,827,594	
I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,318,048	1.00
2.00	OPERATION OF PLANT	7.00	0	4,351,305	2.00
	O		0	9,669,353	
J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,630,833	1.00
2.00		0.00	0	0	2.00
	O		0	16,630,833	
L - PSTD RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	461,496	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
	TOTALS		0	461,496	
500.00	Grand Total: Increases		1,837,705	56,095,765	500.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
10/17/2017 3:54 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAFETERIA							
1.00	DIETARY	10.00	991,039	1,305,044	0		1.00
	O		991,039	1,305,044			
B - CLINICAL TRAINING COST							
1.00	ADULTS & PEDIATRICS	30.00	10,437	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	13,066	0	0		2.00
3.00	OPERATING ROOM	50.00	8,532	0	0		3.00
4.00	ENDOSCOPY	50.01	2,963	0	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	1,698	0	0		5.00
6.00	LABORATORY	60.00	2,618	0	0		6.00
7.00	RESPIRATORY THERAPY	65.00	5,213	0	0		7.00
8.00	EMERGENCY	91.00	99,009	0	0		8.00
	O		143,536	0			
C - SOCIAL WORKERS							
1.00	OTHER A&G	5.05	505,798	0	0		1.00
	O		505,798	0			
E - RESIDENTS							
1.00	EMERGENCY	91.00	0	219,792	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	219,792			
F - MED SUPPLY							
1.00	PURCHASING RECEIVING AND STORES	5.02	0	51,092	0		1.00
2.00	ADMINISTRATIVE	5.03	0	210	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	23	0		3.00
4.00	OTHER A&G	5.05	0	67	0		4.00
5.00	OPERATION OF PLANT	7.00	0	20	0		5.00
6.00	HOUSEKEEPING	9.00	0	8,239	0		6.00
7.00	DIETARY	10.00	0	28	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	1,525	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	117,038	0		9.00
10.00	PHARMACY	15.00	0	18,051	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	708,819	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	203,183	0		12.00
13.00	NEONATAL ICU	31.01	0	1,456	0		13.00
14.00	SUBPROVIDER - IRF	41.00	0	54,809	0		14.00
15.00	NURSERY	43.00	0	40,232	0		15.00
16.00	OPERATING ROOM	50.00	0	12,574,429	0		16.00
17.00	ENDOSCOPY	50.01	0	403,605	0		17.00
18.00	RECOVERY ROOM	51.00	0	16,994	0		18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	0	10,049	0		19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,123	0		20.00
21.00	RADIOLOGY - ULTRASOUND	54.01	0	21,700	0		21.00
22.00	RADIOLOGY-THERAPEUTIC	55.00	0	15,039	0		22.00
23.00	RADIOISOTOPE	56.00	0	217	0		23.00
24.00	CT SCAN	57.00	0	13,417	0		24.00
25.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	679	0		25.00
26.00	CARDIAC CATHETERIZATION	59.00	0	5,434,069	0		26.00
27.00	LABORATORY	60.00	0	1,550	0		27.00
28.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	635	0		28.00
29.00	RESPIRATORY THERAPY	65.00	0	143,892	0		29.00
30.00	PHYSICAL THERAPY	66.00	0	1,657	0		30.00
31.00	OCCUPATIONAL THERAPY	67.00	0	185	0		31.00
32.00	SPEECH PATHOLOGY	68.00	0	335	0		32.00
33.00	ELECTROCARDIOLOGY	69.00	0	1,715	0		33.00
34.00	CARDIAC REHAB	69.01	0	733	0		34.00
35.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,692,585	0		35.00
36.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,324	0		36.00
37.00	RENAL DIALYSIS	74.00	0	1,098	0		37.00
38.00	CLINIC	90.00	0	163,117	0		38.00
39.00	EMERGENCY	91.00	0	175,947	0		39.00
40.00	HOME HEALTH AGENCY	101.00	0	7,037	0		40.00
41.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	48,730	0		41.00
	O		0	23,981,653			
G - LIGHT DUTY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	197,332	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

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
10/17/2017 3:54 pm

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
7.00		0.00	0	0	0		7.00	
8.00		0.00	0	0	0		8.00	
9.00		0.00	0	0	0		9.00	
10.00		0.00	0	0	0		10.00	
11.00		0.00	0	0	0		11.00	
12.00		0.00	0	0	0		12.00	
0			197,332	0				
H - INTEREST EXPENSE								
1.00	OTHER A&G	5.05	0	2,044,364	11		1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	114,602	0		2.00	
3.00	RADIOLOGY - ULTRASOUND	54.01	0	57,301	0		3.00	
4.00	CT SCAN	57.00	0	57,301	0		4.00	
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	57,301	0		5.00	
6.00	OTHER NON-REIMBURSABLE	192.01	0	1,496,725	0		6.00	
0			0	3,827,594				
I - CORPORATE EXPENSE								
1.00	OTHER A&G	5.05	0	9,669,353	9		1.00	
2.00		0.00	0	0	0		2.00	
0			0	9,669,353				
J - DRUG EXPENSE								
1.00	PHARMACY	15.00	0	15,802,755	0		1.00	
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	828,078	0		2.00	
0			0	16,630,833				
L - PSTD RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,870	0	0		1.00	
2.00	DATA PROCESSING	5.01	469	0	0		2.00	
3.00	PURCHASING RECEIVING AND STORES	5.02	2,563	0	0		3.00	
4.00	ADMINISTRATIVE	5.03	1,769	0	0		4.00	
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	12,450	0	0		5.00	
6.00	OTHER A&G	5.05	7,020	0	0		6.00	
7.00	PATIENT TRANSPORTATION	5.06	1,812	0	0		7.00	
8.00	OPERATION OF PLANT	7.00	6,571	0	0		8.00	
9.00	HOUSEKEEPING	9.00	14,665	0	0		9.00	
10.00	DIETARY	10.00	34,150	0	0		10.00	
11.00	NURSING ADMINISTRATION	13.00	2,838	0	0		11.00	
12.00	CENTRAL SERVICES & SUPPLY	14.00	4,696	0	0		12.00	
13.00	MEDICAL RECORDS & LIBRARY	16.00	948	0	0		13.00	
14.00	PARAMEDICAL PROGRAM	23.00	7,105	0	0		14.00	
15.00	ADULTS & PEDIATRICS	30.00	125,205	0	0		15.00	
16.00	INTENSIVE CARE UNIT	31.00	39,024	0	0		16.00	
17.00	NEONATAL ICU	31.01	4,587	0	0		17.00	
18.00	SUBPROVIDER - IRF	41.00	9,026	0	0		18.00	
19.00	NURSERY	43.00	4,374	0	0		19.00	
20.00	OPERATING ROOM	50.00	13,139	0	0		20.00	
21.00	ENDOSCOPY	50.01	3,332	0	0		21.00	
22.00	RECOVERY ROOM	51.00	254	0	0		22.00	
23.00	DELIVERY ROOM & LABOR ROOM	52.00	18,493	0	0		23.00	
24.00	RADIOLOGY-DIAGNOSTIC	54.00	2,364	0	0		24.00	
25.00	RADIOLOGY-THERAPEUTIC	55.00	7,387	0	0		25.00	
26.00	LABORATORY	60.00	7,121	0	0		26.00	
27.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	8,377	0	0		27.00	
28.00	RESPIRATORY THERAPY	65.00	13,943	0	0		28.00	
29.00	PHYSICAL THERAPY	66.00	23,047	0	0		29.00	
30.00	OCCUPATIONAL THERAPY	67.00	2,606	0	0		30.00	
31.00	ELECTROENCEPHALOGRAPHY	70.00	2,462	0	0		31.00	
32.00	CLINIC	90.00	10,413	0	0		32.00	
33.00	EMERGENCY	91.00	44,622	0	0		33.00	
34.00	HOME HEALTH AGENCY	101.00	3,847	0	0		34.00	
35.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	624	0	0		35.00	
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,757	0	0		36.00	
37.00	OTHER NON-REIMBURSABLE	192.01	1,566	0	0		37.00	
0	TOTALS		461,496	0				
500.00	Grand Total: Decreases		2,299,201	55,634,269			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,745,499	0	0	0	0	1.00
2.00	Land Improvements	6,297,211	72,941	0	72,941	0	2.00
3.00	Buildings and Fixtures	248,982,397	4,432,612	0	4,432,612	152,690	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	239,765,702	13,452,090	0	13,452,090	76,885,138	6.00
7.00	HIT designated Assets	3,535,559	321,551	0	321,551	0	7.00
8.00	Subtotal (sum of lines 1-7)	502,326,368	18,279,194	0	18,279,194	77,037,828	8.00
9.00	Reconciling Items	-20,950	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	502,347,318	18,279,194	0	18,279,194	77,037,828	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,745,499	0				1.00
2.00	Land Improvements	6,370,152	0				2.00
3.00	Buildings and Fixtures	253,262,319	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	176,332,654	0				6.00
7.00	HIT designated Assets	3,857,110	0				7.00
8.00	Subtotal (sum of lines 1-7)	443,567,734	0				8.00
9.00	Reconciling Items	-20,950	0				9.00
10.00	Total (line 8 minus line 9)	443,588,684	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part II
Date/Time Prepared:
10/17/2017 3:54 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part III
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,532,367	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	4,532,367	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,783,230	0	0	0	6,315,597	1.00
3.00	Total (sum of lines 1-2)	1,783,230	0	0	0	6,315,597	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0002

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

Worksheet A-8

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,044,364	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***		2.00		2.00
3.00 Investment income - other (chapter 2)		0			0.00		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00		7.00
8.00 Television and radio service (chapter 21)		0			0.00		8.00
9.00 Parking lot (chapter 21)		0			0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-951,770					10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00		11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0					12.00
13.00 Laundry and linen service		0			0.00		13.00
14.00 Cafeteria-employees and guests	B	-853,443	CAFETERIA		11.00		14.00
15.00 Rental of quarters to employee and others		0			0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00		16.00
17.00 Sale of drugs to other than patients		0			0.00		17.00
18.00 Sale of medical records and abstracts	B	-2,499	MEDICAL RECORDS & LIBRARY		16.00		18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		19.00
20.00 Vending machines	B	-29,882	DIETARY		10.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		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	A	-785,681	CAP REL COSTS-BLDG & FIXT		1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***		2.00		27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00 Physicians' assistant		0			0.00		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		32.00
33.00 DATA PROCESSING OTHER INCOME	B	-146,200	DATA PROCESSING		5.01		33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0002

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

Worksheet A-8

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
34.00 CASH, A/R, COLLECTIONS OTHER INCOME	B	-16,982	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	34.00
35.00 A&G OTHER INCOME	B	-383,195	OTHER A&G	5.05	0	35.00
36.00 ENVIRONMENTAL SERVICES OTHER INCOME	B	-1,285	HOUSEKEEPING	9.00	0	36.00
37.00 NURSING ADMIN OTHER INCOME	B	-4,605	NURSING ADMINISTRATION	13.00	0	37.00
38.00 PARAMEDICAL PROGRAM OTHER INCOME	B	-391,387	PARAMEDICAL PROGRAM	23.00	0	38.00
39.00 ADULTS & PEDIATRICS OTHER INCOME	B	-189,057	ADULTS & PEDIATRICS	30.00	0	39.00
40.00 LAB OTHER INCOME	B	-38,723	LABORATORY	60.00	0	40.00
41.00 BLOOD OTHER INCOME	B	-143,838	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	41.00
42.00 CARDIAC REHAB OTHER INCOME	B	-66,139	CARDIAC REHAB	69.01	0	42.00
43.00 ELECTROENCEPHALOGRAPHY OTHER INCOME	B	-5,778	ELECTROENCEPHALOGRAPHY	70.00	0	43.00
44.00 CLINIC OTHER INCOME	B	-1,193	CLINIC	90.00	0	44.00
45.00 LOBBYING EXPENSE	A	-66,442	OTHER A&G	5.05	0	45.00
46.00 IHA EXPENSE	A	-18,401	OTHER A&G	5.05	0	46.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,140,864				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0002

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

Worksheet A-8-2

Date/Time Prepared:
10/17/2017 3:54 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	30.00	ADULTS & PEDIATRICS	293,196	293,196	0	179,000	0	1.00
2.00	31.01	NEONATAL ICU	546,000	546,000	0	169,700	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	2,928	2,928	0	271,900	0	3.00
4.00	57.00	CT SCAN	1,551	1,551	0	271,900	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	6,795	6,795	0	179,000	0	5.00
6.00	90.00	CLINIC	101,300	101,300	0	179,000	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			951,770	951,770	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.01	NEONATAL ICU	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	57.00	CT SCAN	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	293,196	1.00
2.00	31.01	NEONATAL ICU	0	0	0	546,000	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,928	3.00
4.00	57.00	CT SCAN	0	0	0	1,551	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	6,795	5.00
6.00	90.00	CLINIC	0	0	0	101,300	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	951,770	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		RELATED COSTS BLDG & FIXT				
	0	1.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,315,597	6,315,597			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	25,239,169	26,451	25,265,620		4.00
5.01 00550	DATA PROCESSING	14,491,053	41,159	747,929	15,280,141	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	3,191,078	32,838	168,058	0	5.02
5.03 00570	ADMITTING	2,586,730	43,520	370,807	0	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,765,786	137,255	366,861	0	5.04
5.05 00590	OTHER A&G	22,454,170	445,987	1,899,030	15,280,141	5.05
5.06 00592	PATIENT TRANSPORTATION	633,293	0	102,573	0	5.06
7.00 00700	OPERATION OF PLANT	14,720,773	1,340,612	624,798	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,444,372	79,833	0	0	8.00
9.00 00900	HOUSEKEEPING	6,037,201	92,418	836,665	0	9.00
10.00 01000	DIETARY	4,143,812	84,415	371,724	0	10.00
11.00 01100	CAFETERIA	1,832,389	59,016	241,180	0	11.00
13.00 01300	NURSING ADMINISTRATION	3,007,843	28,440	457,792	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,397,877	160,531	97,654	0	14.00
15.00 01500	PHARMACY	-18,051	84,903	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,979,298	50,641	361,514	0	16.00
17.00 01700	SOCIAL SERVICE	505,798	7,296	91,283	0	17.00
17.01 01701	STAFF EDUCATION	0	49,924	0	0	17.01
17.02 01702	MEDICAL EDUCATION	92,420	1,675	12,776	0	17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	210,204	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	9,588	20,006	0	0	22.00
23.00 02300	PARAMED ED PROGRAM	200,161	15,066	92,069	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	35,918,080	1,402,815	5,472,123	0	30.00
31.00 03100	INTENSIVE CARE UNIT	7,492,154	88,965	1,121,842	0	31.00
31.01 03101	NEONATAL ICU	2,452,814	10,113	408,801	0	31.01
40.00 04000	SUBPROVIDER - I PF	746,192	17,789	122,360	0	40.00
41.00 04100	SUBPROVIDER - I RF	3,471,003	139,929	549,500	0	41.00
43.00 04300	NURSERY	849,788	109,388	111,486	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,886,880	267,142	755,873	0	50.00
50.01 05001	ENDOSCOPY	3,051,248	0	219,237	0	50.01
51.00 05100	RECOVERY ROOM	1,063,679	65,148	171,222	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,129,001	31,365	469,612	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,317,126	237,637	414,270	0	54.00
54.01 05401	RADIOLOGY - ULTRASOUND	1,704,413	22,635	234,874	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,439,318	60,396	93,675	0	55.00
56.00 05600	RADIOISOTOPE	1,416,375	40,501	89,507	0	56.00
57.00 05700	CT SCAN	1,857,863	38,351	185,319	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	530,438	18,833	73,195	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	3,989,053	37,590	360,820	0	59.00
60.00 06000	LABORATORY	10,136,246	105,331	634,071	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,377,331	1,724	208,927	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	3,165,920	34,782	424,378	0	65.00
66.00 06600	PHYSICAL THERAPY	1,545,568	54,954	255,666	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,210,599	47,228	192,897	0	67.00
68.00 06800	SPEECH PATHOLOGY	442,921	8,044	71,681	0	68.00
69.00 06900	ELECTROCARDIOLOGY	891,339	0	110,689	0	69.00
69.01 06901	CARDIAC REHAB	729,111	0	68,003	0	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	1,091,934	0	156,021	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,196,173	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	12,785,480	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	17,500,165	7,444	77,419	0	73.00
74.00 07400	RENAL DIALYSIS	1,788,109	19,630	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	4,436,646	341,194	406,730	0	90.00
91.00 09100	EMERGENCY	8,775,913	121,208	1,159,592	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	2,167,849	0	330,806	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	276,797,290	6,132,122	21,793,309	15,280,141	3,347,176

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES		
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	244,231	8,066	10,150	0	15,294	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,871,284	119,631	2,868,667	0	29,445	192.00
192.01	19201	OTHER NON-REIMBURSABLE	4,545,453	15,483	564,026	0	59	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	211,904	40,295	29,468	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	314,670,162	6,315,597	25,265,620	15,280,141	3,391,974	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

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Cost Center Description		ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
		5.03	5.04	5A.04	5.05	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00570	3,005,015					5.03
5.04	00580	0	4,271,826				5.04
5.05	00590	0	0	40,086,003	40,086,003		5.05
5.06	00592	0	0	736,056	107,455	843,511	5.06
7.00	00700	0	0	16,715,285	2,440,231	0	7.00
8.00	00800	0	0	1,524,396	222,544	0	8.00
9.00	00900	0	0	7,008,011	1,023,086	0	9.00
10.00	01000	0	0	4,635,537	676,733	0	10.00
11.00	01100	0	0	2,132,630	311,338	0	11.00
13.00	01300	0	0	3,495,325	510,276	0	13.00
14.00	01400	0	0	2,713,037	396,071	0	14.00
15.00	01500	0	0	75,841	11,072	0	15.00
16.00	01600	0	0	3,392,391	495,248	16	16.00
17.00	01700	0	0	604,377	88,232	0	17.00
17.01	01701	0	0	49,924	7,288	0	17.01
17.02	01702	0	0	106,903	15,607	0	17.02
21.00	02100	0	0	210,204	30,687	0	21.00
22.00	02200	0	0	29,594	4,320	0	22.00
23.00	02300	0	0	307,781	44,932	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	241,783	343,747	43,552,554	6,358,159	363,120	30.00
31.00	03100	42,719	60,735	8,859,917	1,293,442	6,511	31.00
31.01	03101	14,846	21,106	2,908,043	424,539	0	31.01
40.00	04000	5,350	7,606	899,344	131,293	572	40.00
41.00	04100	20,941	29,772	4,219,609	616,012	9,655	41.00
43.00	04300	4,969	7,065	1,093,918	159,699	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	409,408	581,601	9,974,497	1,456,157	0	50.00
50.01	05001	57,021	81,068	3,468,930	506,422	23,819	50.01
51.00	05100	25,938	36,877	1,366,110	199,436	79	51.00
52.00	05200	19,685	27,987	3,687,344	538,308	5,875	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	89,080	126,647	5,198,961	758,986	93,452	54.00
54.01	05401	39,581	56,272	2,071,647	302,436	89,307	54.01
55.00	05500	42,260	60,081	1,698,126	247,906	6,971	55.00
56.00	05600	31,460	44,728	1,684,464	245,912	44,796	56.00
57.00	05700	256,635	364,863	2,730,210	398,578	118,542	57.00
58.00	05800	66,940	95,170	791,669	115,574	41,954	58.00
59.00	05900	233,453	331,905	4,988,356	728,240	25,010	59.00
60.00	06000	345,451	491,135	11,953,524	1,745,071	16	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100						61.00
62.00	06200	5,379	7,648	1,623,580	237,023	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	117,575	167,159	3,949,708	576,610	1,699	65.00
66.00	06600	19,077	27,122	1,903,379	277,870	0	66.00
67.00	06700	14,396	20,467	1,486,909	217,071	0	67.00
68.00	06800	5,034	7,157	535,439	78,168	0	68.00
69.00	06900	47,207	67,116	1,117,816	163,188	3,748	69.00
69.01	06901	1,610	2,288	801,634	117,029	0	69.01
70.00	07000	102,674	145,973	1,496,602	218,486	7,003	70.00
71.00	07100	0	0	12,178,481	1,777,912	0	71.00
72.00	07200	0	0	13,907,244	2,030,291	0	72.00
73.00	07300	335,125	476,454	18,441,224	2,692,197	0	73.00
74.00	07400	18,617	26,469	1,853,954	270,655	16	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	56,652	80,544	5,327,977	777,821	143	90.00
91.00	09100	208,290	296,129	10,691,077	1,560,769	1,207	91.00
92.00	09200			0			92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	9,096	12,932	2,528,398	369,116	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		2,888,252	4,105,823	272,813,940	33,975,496	843,511	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	277,741	40,547	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	102,671	145,969	36,137,667	5,275,666	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
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Cost Center Description			ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION
			5.03	5.04	5A.04	5.05	5.06
192.01	19201	OTHER NON-REIMBURSABLE	14,092	20,034	5,159,147	753,174	0
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	281,667	41,120	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments			0		0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,005,015	4,271,826	314,670,162	40,086,003	843,511

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT	19,155,516				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	360,011	2,106,951			8.00
9.00	00900	HOUSEKEEPING	416,765	0	8,447,862		9.00
10.00	01000	DIETARY	380,673	0	174,978	5,867,921	10.00
11.00	01100	CAFETERIA	266,136	0	122,330	0	2,832,434
13.00	01300	NURSING ADMINISTRATION	128,251	0	58,951	0	62,045
14.00	01400	CENTRAL SERVICES & SUPPLY	723,921	23,272	332,753	0	33,549
15.00	01500	PHARMACY	382,874	12	175,990	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	228,367	0	104,970	0	88,903
17.00	01700	SOCIAL SERVICE	32,901	0	15,123	0	17,989
17.01	01701	STAFF EDUCATION	225,136	0	103,485	0	0
17.02	01702	MEDICAL EDUCATION	7,554	0	3,472	0	2,181
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	90,220	0	41,470	0	0
23.00	02300	PARAMED ED PROGRAM	67,943	0	31,230	0	20,131
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,326,045	998,808	2,907,791	4,001,922	1,041,137
31.00	03100	INTENSIVE CARE UNIT	401,193	52,875	184,410	805,163	167,977
31.01	03101	NEONATAL ICU	45,605	46,673	20,962	0	55,736
40.00	04000	SUBPROVIDER - I PF	80,222	0	36,875	0	20,708
41.00	04100	SUBPROVIDER - I RF	631,015	0	290,048	543,208	104,829
43.00	04300	NURSERY	493,291	43,387	226,743	0	16,163
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,204,690	210,323	553,741	0	132,307
50.01	05001	ENDOSCOPY	0	27,950	0	106	37,475
51.00	05100	RECOVERY ROOM	293,785	55,056	135,040	239,832	25,330
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,440	47,036	65,013	0	77,710
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,071,632	69,935	492,580	0	81,833
54.01	05401	RADIOLOGY - ULTRASOUND	102,076	11,866	46,919	0	31,232
55.00	05500	RADIOLOGY-THERAPEUTIC	272,356	3,170	125,190	0	13,450
56.00	05600	RADIOISOTOPE	182,641	25,658	83,952	0	12,191
57.00	05700	CT SCAN	172,947	16,118	79,496	0	30,760
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,928	6,444	39,038	0	11,181
59.00	05900	CARDIAC CATHETERIZATION	169,513	46,040	77,918	55,209	52,525
60.00	06000	LABORATORY	474,993	0	218,332	0	121,163
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,776	0	3,574	0	65,005
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	156,850	3,097	72,097	0	78,400
66.00	06600	PHYSICAL THERAPY	247,817	25,405	113,910	0	41,202
67.00	06700	OCCUPATIONAL THERAPY	212,977	0	97,896	0	28,760
68.00	06800	SPEECH PATHOLOGY	36,274	0	16,673	11,733	9,715
69.00	06900	ELECTROCARDIOLOGY	0	12,076	0	0	23,269
69.01	06901	CARDIAC REHAB	0	4,080	0	0	11,947
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	287	24,802
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	33,567	0	15,429	0	10,786
74.00	07400	RENAL DIALYSIS	88,523	96,910	40,690	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,538,627	44,085	707,236	0	67,690
91.00	09100	EMERGENCY	546,591	224,735	251,243	210,461	208,061
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,328,126	2,095,011	8,067,548	5,867,921	2,828,142
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,375	0	16,720	0	4,292
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	539,482	11,940	247,975	0	0
192.01	19201	OTHER NON-REIMBURSABLE	69,821	0	32,094	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
192.02	19202 FAMILY HEALTH/GARY COMM HEALTH	181,712	0	83,525	0	0	192.02
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	19,155,516	2,106,951	8,447,862	5,867,921	2,832,434	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part I Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	4,254,848					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,222,603				14.00
15.00	01500	PHARMACY	0	0	645,789			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,309,895		16.00
17.00	01700	SOCIAL SERVICE	39,750	0	0	0	798,372	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	44,482	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,300,576	0	0	374,234	617,966	30.00
31.00	03100	INTENSIVE CARE UNIT	371,175	0	0	61,336	0	31.00
31.01	03101	NEONATAL ICU	123,159	0	0	21,997	0	31.01
40.00	04000	SUBPROVIDER - I PF	45,759	0	0	7,968	0	40.00
41.00	04100	SUBPROVIDER - I RF	231,638	0	0	31,264	141,534	41.00
43.00	04300	NURSERY	35,715	0	0	7,187	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	292,356	0	0	538,867	0	50.00
50.01	05001	ENDOSCOPY	82,809	0	0	74,207	0	50.01
51.00	05100	RECOVERY ROOM	55,970	0	0	38,729	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	171,713	0	0	20,978	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	132,641	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	58,050	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	62,786	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	46,974	0	56.00
57.00	05700	CT SCAN	0	0	0	379,243	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	99,924	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	262,771	0	59.00
60.00	06000	LABORATORY	0	0	87,156	493,475	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	29,929	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	150,272	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,484	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	21,332	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,499	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	70,486	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	2,395	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	39,503	114,636	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,971,378	0	179,003	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,251,225	0	122,046	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	502,675	493,130	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	27,765	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	82,299	0	90.00
91.00	09100	EMERGENCY	459,746	0	0	254,603	38,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	1,175	13,385	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,254,848	4,222,603	630,509	4,309,895	798,372	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	15,280	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
			ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
			13.00	14.00	15.00	16.00	17.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,254,848	4,222,603	645,789	4,309,895	798,372	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED PROGRAM		
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.01	17.02			21.00
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.01 00550 DATA PROCESSING						5.01	
5.02 00560 PURCHASING RECEIVING AND STORES						5.02	
5.03 00570 ADMITTING						5.03	
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04	
5.05 00590 OTHER A&G						5.05	
5.06 00592 PATIENT TRANSPORTATION						5.06	
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						17.00	
17.01 01701 STAFF EDUCATION	385,833					17.01	
17.02 01702 MEDICAL EDUCATION	0	135,717				17.02	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	240,891			21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	165,604		22.00	
23.00 02300 PARAMED PROGRAM	181	0	0	0	516,680	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	186,190	0	0	0	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	28,076	0	0	0	0	31.00	
31.01 03101 NEONATAL ICU	13,025	0	0	0	0	31.01	
40.00 04000 SUBPROVIDER - I PF	3,306	0	0	0	0	40.00	
41.00 04100 SUBPROVIDER - I RF	27,120	0	0	0	0	41.00	
43.00 04300 NURSERY	1,760	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	20,158	0	0	0	0	50.00	
50.01 05001 ENDOSCOPY	2,570	0	0	0	0	50.01	
51.00 05100 RECOVERY ROOM	3,779	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	12,659	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,520	0	0	0	0	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	1,899	0	0	0	0	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	1,138	0	0	0	0	55.00	
56.00 05600 RADIOISOTOPE	65	0	0	0	0	56.00	
57.00 05700 CT SCAN	1,397	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	9,907	0	0	0	0	59.00	
60.00 06000 LABORATORY	2,048	0	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	78	0	0	0	0	62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	2,165	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	113	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	233	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	165	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	2,275	0	0	0	0	69.00	
69.01 06901 CARDIAC REHAB	126	0	0	0	0	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	1,792	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	1,228	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	1,163	0	0	0	0	90.00	
91.00 09100 EMERGENCY	51,634	135,717	240,891	165,604	516,680	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	3,231	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	383,004	135,717	240,891	165,604	516,680	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

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Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.01	17.02		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2,829	0	0	0	0	0 192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	0 192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	0 192.02
193.00 19300 NONPAID WORKERS	0	0	0	0	0	0 193.00
200.00 Cross Foot Adjustments			0	0	0	0 200.00
201.00 Negative Cost Centers	0	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	385,833	135,717	240,891	165,604	516,680	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	69,028,502	0	69,028,502	30.00
31.00	03100	12,232,075	0	12,232,075	31.00
31.01	03101	3,659,739	0	3,659,739	31.01
40.00	04000	1,226,047	0	1,226,047	40.00
41.00	04100	6,845,932	0	6,845,932	41.00
43.00	04300	2,077,863	0	2,077,863	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	14,383,096	0	14,383,096	50.00
50.01	05001	4,224,288	0	4,224,288	50.01
51.00	05100	2,413,146	0	2,413,146	51.00
52.00	05200	4,768,076	0	4,768,076	52.00
53.00	05300	0	0	0	53.00
54.00	05400	7,903,540	0	7,903,540	54.00
54.01	05401	2,715,432	0	2,715,432	54.01
55.00	05500	2,431,093	0	2,431,093	55.00
56.00	05600	2,326,653	0	2,326,653	56.00
57.00	05700	3,927,291	0	3,927,291	57.00
58.00	05800	1,190,715	0	1,190,715	58.00
59.00	05900	6,415,489	0	6,415,489	59.00
60.00	06000	15,095,778	0	15,095,778	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	1,966,965	0	1,966,965	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	4,990,898	0	4,990,898	65.00
66.00	06600	2,638,180	0	2,638,180	66.00
67.00	06700	2,065,178	0	2,065,178	67.00
68.00	06800	695,666	0	695,666	68.00
69.00	06900	1,392,858	0	1,392,858	69.00
69.01	06901	937,211	0	937,211	69.01
70.00	07000	1,903,111	0	1,903,111	70.00
71.00	07100	16,106,774	0	16,106,774	71.00
72.00	07200	18,310,806	0	18,310,806	72.00
73.00	07300	22,190,236	0	22,190,236	73.00
74.00	07400	2,378,513	0	2,378,513	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	8,547,041	0	8,547,041	90.00
91.00	09100	15,557,891	-406,495	15,151,396	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	2,915,305	0	2,915,305	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		265,461,388	-406,495	265,054,893	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	375,675	0	375,675	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2015
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,230,839	0	42,230,839	192.00
192.01	19201	OTHER NON-REIMBURSABLE	6,014,236	0	6,014,236	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	588,024	0	588,024	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	314,670,162	-406,495	314,263,667	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			BLDG & FIXT				
	0		1.00	2A	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	26,451	26,451	26,451		4.00
5.01 00550	DATA PROCESSING	0	41,159	41,159	783	41,942	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	32,838	32,838	176	0	5.02
5.03 00570	ADMINISTRATIVE	0	43,520	43,520	388	0	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	137,255	137,255	384	0	5.04
5.05 00590	OTHER A&G	0	445,987	445,987	1,989	41,942	5.05
5.06 00592	PATIENT TRANSPORTATION	0	0	0	107	0	5.06
7.00 00700	OPERATION OF PLANT	0	1,340,612	1,340,612	654	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	79,833	79,833	0	0	8.00
9.00 00900	HOUSEKEEPING	0	92,418	92,418	876	0	9.00
10.00 01000	DIETARY	0	84,415	84,415	389	0	10.00
11.00 01100	CAFETERIA	0	59,016	59,016	253	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	28,440	28,440	479	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	160,531	160,531	102	0	14.00
15.00 01500	PHARMACY	0	84,903	84,903	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	50,641	50,641	379	0	16.00
17.00 01700	SOCIAL SERVICE	0	7,296	7,296	96	0	17.00
17.01 01701	STAFF EDUCATION	0	49,924	49,924	0	0	17.01
17.02 01702	MEDICAL EDUCATION	0	1,675	1,675	13	0	17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	20,006	20,006	0	0	22.00
23.00 02300	PARAMED PROGRAM	0	15,066	15,066	96	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	1,402,815	1,402,815	5,724	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	88,965	88,965	1,175	0	31.00
31.01 03101	NEONATAL ICU	0	10,113	10,113	428	0	31.01
40.00 04000	SUBPROVIDER - I/PF	0	17,789	17,789	128	0	40.00
41.00 04100	SUBPROVIDER - I/RF	0	139,929	139,929	575	0	41.00
43.00 04300	NURSERY	0	109,388	109,388	117	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	267,142	267,142	792	0	50.00
50.01 05001	ENDOSCOPY	0	0	0	230	0	50.01
51.00 05100	RECOVERY ROOM	0	65,148	65,148	179	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	31,365	31,365	492	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	237,637	237,637	434	0	54.00
54.01 05401	RADIOLOGY - ULTRASOUND	0	22,635	22,635	246	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	60,396	60,396	98	0	55.00
56.00 05600	RADIOISOTOPE	0	40,501	40,501	94	0	56.00
57.00 05700	CT SCAN	0	38,351	38,351	194	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	18,833	18,833	77	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	37,590	37,590	378	0	59.00
60.00 06000	LABORATORY	0	105,331	105,331	664	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,724	1,724	219	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	34,782	34,782	444	0	65.00
66.00 06600	PHYSICAL THERAPY	0	54,954	54,954	268	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	47,228	47,228	202	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	8,044	8,044	75	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	116	0	69.00
69.01 06901	CARDIAC REHAB	0	0	0	71	0	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	163	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	7,444	7,444	81	0	73.00
74.00 07400	RENAL DIALYSIS	0	19,630	19,630	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	341,194	341,194	426	0	90.00
91.00 09100	EMERGENCY	0	121,208	121,208	1,214	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	346	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6,132,122	6,132,122	22,814	41,942	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
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To 12/31/2015

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING		
			BLDG & FIXT					
	0		1.00	2A	4.00	5.01		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,066	8,066	11	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	119,631	119,631	3,004	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	15,483	15,483	591	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	40,295	40,295	31	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	6,315,597	6,315,597	26,451	41,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	33,014					5.02
5.03	00570	ADMINITTING	39	43,947				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	19	0	137,658			5.04
5.05	00590	OTHER A&G	65	0	0	489,983		5.05
5.06	00592	PATIENT TRANSPORTATION	2	0	0	1,313	1,422	5.06
7.00	00700	OPERATION OF PLANT	283	0	0	29,820	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	0	0	2,720	0	8.00
9.00	00900	HOUSEKEEPING	406	0	0	12,502	0	9.00
10.00	01000	DIETARY	346	0	0	8,270	0	10.00
11.00	01100	CAFETERIA	0	0	0	3,805	0	11.00
13.00	01300	NURSING ADMINISTRATION	12	0	0	6,236	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	555	0	0	4,840	0	14.00
15.00	01500	PHARMACY	87	0	0	135	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9	0	0	6,052	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,078	0	17.00
17.01	01701	STAFF EDUCATION	0	0	0	89	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	191	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	375	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	53	0	22.00
23.00	02300	PARAMED ED PROGRAM	5	0	0	549	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,694	3,507	11,060	77,823	611	30.00
31.00	03100	INTENSIVE CARE UNIT	521	620	1,954	15,806	11	31.00
31.01	03101	NEONATAL ICU	4	215	679	5,188	0	31.01
40.00	04000	SUBPROVIDER - I/PF	0	78	245	1,604	1	40.00
41.00	04100	SUBPROVIDER - I/RF	82	304	958	7,528	16	41.00
43.00	04300	NURSERY	109	72	227	1,952	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	716	6,300	18,930	17,795	0	50.00
50.01	05001	ENDOSCOPY	587	827	2,608	6,189	40	50.01
51.00	05100	RECOVERY ROOM	32	376	1,186	2,437	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94	286	900	6,578	10	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138	1,292	4,075	9,275	158	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	135	574	1,810	3,696	151	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	23	613	1,933	3,029	12	55.00
56.00	05600	RADIOISOTOPE	602	456	1,439	3,005	76	56.00
57.00	05700	CT SCAN	265	3,722	11,739	4,871	200	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	69	971	3,062	1,412	71	58.00
59.00	05900	CARDIAC CATHETERIZATION	346	3,386	10,679	8,899	42	59.00
60.00	06000	LABORATORY	2,349	5,010	15,802	21,325	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	220	78	246	2,896	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	388	1,705	5,378	7,046	3	65.00
66.00	06600	PHYSICAL THERAPY	10	277	873	3,396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13	209	658	2,653	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	73	230	955	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14	685	2,159	1,994	6	69.00
69.01	06901	CARDIAC REHAB	6	23	74	1,430	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,489	4,697	2,670	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,562	0	0	21,726	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,917	0	0	24,811	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	434	4,861	15,329	32,899	0	73.00
74.00	07400	RENAL DIALYSIS	11	270	852	3,307	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	60	822	2,591	9,505	0	90.00
91.00	09100	EMERGENCY	1,265	3,021	9,528	19,073	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	75	132	416	4,511	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,577	42,254	132,317	415,312	1,422	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	149	0	0	495	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	287	1,489	4,696	64,470	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
192.01	19201	OTHER NON-REIMBURSABLE	1	204	645	9,204	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	502	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,014	43,947	137,658	489,983	1,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00570	ADMITTING					5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04	
5.05	00590	OTHER A&G					5.05	
5.06	00592	PATIENT TRANSPORTATION					5.06	
7.00	00700	OPERATION OF PLANT	1,371,369				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	25,774	108,329			8.00	
9.00	00900	HOUSEKEEPING	29,837	0	136,039		9.00	
10.00	01000	DIETARY	27,253	0	2,818	123,491	10.00	
11.00	01100	CAFETERIA	19,053	0	1,970	0	84,097	11.00
13.00	01300	NURSING ADMINISTRATION	9,182	0	949	0	1,842	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,826	1,197	5,358	0	996	14.00
15.00	01500	PHARMACY	27,410	1	2,834	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,349	0	1,690	0	2,640	16.00
17.00	01700	SOCIAL SERVICE	2,355	0	244	0	534	17.00
17.01	01701	STAFF EDUCATION	16,118	0	1,666	0	0	17.01
17.02	01702	MEDICAL EDUCATION	541	0	56	0	65	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,459	0	668	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	4,864	0	503	0	598	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	452,891	51,351	46,825	84,221	30,915	30.00
31.00	03100	INTENSIVE CARE UNIT	28,722	2,719	2,970	16,945	4,987	31.00
31.01	03101	NEONATAL ICU	3,265	2,400	338	0	1,655	31.01
40.00	04000	SUBPROVIDER - I PF	5,743	0	594	0	615	40.00
41.00	04100	SUBPROVIDER - I RF	45,175	0	4,671	11,432	3,112	41.00
43.00	04300	NURSERY	35,315	2,231	3,651	0	480	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	86,245	10,814	8,917	0	3,928	50.00
50.01	05001	ENDOSCOPY	0	1,437	0	2	1,113	50.01
51.00	05100	RECOVERY ROOM	21,032	2,831	2,175	5,047	752	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,126	2,418	1,047	0	2,307	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,720	3,596	7,932	0	2,430	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	7,308	610	756	0	927	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	19,498	163	2,016	0	399	55.00
56.00	05600	RADIOISOTOPE	13,076	1,319	1,352	0	362	56.00
57.00	05700	CT SCAN	12,381	829	1,280	0	913	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,080	331	629	0	332	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,136	2,367	1,255	1,162	1,559	59.00
60.00	06000	LABORATORY	34,005	0	3,516	0	3,597	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	557	0	58	0	1,930	62.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,229	159	1,161	0	2,328	65.00
66.00	06600	PHYSICAL THERAPY	17,742	1,306	1,834	0	1,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,247	0	1,576	0	854	67.00
68.00	06800	SPEECH PATHOLOGY	2,597	0	268	247	288	68.00
69.00	06900	ELECTROCARDIOLOGY	0	621	0	0	691	69.00
69.01	06901	CARDIAC REHAB	0	210	0	0	355	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6	736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,403	0	248	0	320	73.00
74.00	07400	RENAL DIALYSIS	6,338	4,983	655	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	110,152	2,267	11,389	0	2,010	90.00
91.00	09100	EMERGENCY	39,131	11,555	4,046	4,429	6,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,312,135	107,715	129,915	123,491	83,970	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,604	0	269	0	127	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,622	614	3,993	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	4,999	0	517	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002			Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
			7.00	8.00	9.00	10.00	11.00		
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	13,009	0	1,345	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,371,369	108,329	136,039	123,491	84,097		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	47,140					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	225,405				14.00
15.00	01500	PHARMACY	0	0	112,233			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	77,760		16.00
17.00	01700	SOCIAL SERVICE	440	0	0	0	12,043	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	493	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,490	0	0	6,711	9,322	30.00
31.00	03100	INTENSIVE CARE UNIT	4,112	0	0	1,100	0	31.00
31.01	03101	NEONATAL ICU	1,364	0	0	394	0	31.01
40.00	04000	SUBPROVIDER - I PF	507	0	0	143	0	40.00
41.00	04100	SUBPROVIDER - I RF	2,566	0	0	561	2,135	41.00
43.00	04300	NURSERY	396	0	0	129	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,239	0	0	10,133	0	50.00
50.01	05001	ENDOSCOPY	917	0	0	1,331	0	50.01
51.00	05100	RECOVERY ROOM	620	0	0	695	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,902	0	0	376	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,379	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	1,041	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,126	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	842	0	56.00
57.00	05700	CT SCAN	0	0	0	6,801	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,792	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,712	0	59.00
60.00	06000	LABORATORY	0	0	15,148	8,849	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	537	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	511	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	383	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	134	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,264	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	43	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6,866	2,056	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	105,233	0	3,210	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,172	0	2,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	87,359	8,843	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	498	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,476	0	90.00
91.00	09100	EMERGENCY	5,094	0	0	4,566	586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	204	240	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,140	225,405	109,577	77,760	12,043	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,656	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm		
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
			13.00	14.00	15.00	16.00	17.00		
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	3,137	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,140	225,405	115,370	77,760	12,043		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED PROGRAM	
	17.01	17.02	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER A&G					5.05
5.06 00592	PATIENT TRANSPORTATION					5.06
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					17.00
17.01 01701	STAFF EDUCATION	67,797				17.01
17.02 01702	MEDICAL EDUCATION	0	2,541			17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	375		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		27,186	22.00
23.00 02300	PARAMED PROGRAM	32	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	32,717	0			30.00
31.00 03100	INTENSIVE CARE UNIT	4,933	0			31.00
31.01 03101	NEONATAL ICU	2,289	0			31.01
40.00 04000	SUBPROVIDER - I PF	581	0			40.00
41.00 04100	SUBPROVIDER - I RF	4,765	0			41.00
43.00 04300	NURSERY	309	0			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,542	0			50.00
50.01 05001	ENDOSCOPY	452	0			50.01
51.00 05100	RECOVERY ROOM	664	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,224	0			52.00
53.00 05300	ANESTHESIOLOGY	0	0			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	618	0			54.00
54.01 05401	RADIOLOGY - ULTRASOUND	334	0			54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	200	0			55.00
56.00 05600	RADIOISOTOPE	11	0			56.00
57.00 05700	CT SCAN	245	0			57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1	0			58.00
59.00 05900	CARDIAC CATHETERIZATION	1,741	0			59.00
60.00 06000	LABORATORY	360	0			60.00
60.01 06001	BLOOD LABORATORY	0	0			60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14	0			62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00 06400	INTRAVENOUS THERAPY	0	0			64.00
65.00 06500	RESPIRATORY THERAPY	380	0			65.00
66.00 06600	PHYSICAL THERAPY	20	0			66.00
67.00 06700	OCCUPATIONAL THERAPY	41	0			67.00
68.00 06800	SPEECH PATHOLOGY	29	0			68.00
69.00 06900	ELECTROCARDIOLOGY	400	0			69.00
69.01 06901	CARDIAC REHAB	22	0			69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	315	0			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	216	0			73.00
74.00 07400	RENAL DIALYSIS	0	0			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	204	0			90.00
91.00 09100	EMERGENCY	9,073	2,541			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	568	0			101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,300	2,541	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
191.00 19100	RESEARCH	0	0			191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.01	17.02		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	497	0				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0				192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0				192.02
193.00 19300 NONPAID WORKERS	0	0				193.00
200.00 Cross Foot Adjustments			375	27,186	22,206	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	67,797	2,541	375	27,186	22,206	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,243,677	0	2,243,677	30.00
31.00	03100	175,540	0	175,540	31.00
31.01	03101	28,332	0	28,332	31.01
40.00	04000	28,028	0	28,028	40.00
41.00	04100	223,809	0	223,809	41.00
43.00	04300	154,376	0	154,376	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	438,493	0	438,493	50.00
50.01	05001	15,733	0	15,733	50.01
51.00	05100	103,174	0	103,174	51.00
52.00	05200	60,125	0	60,125	52.00
53.00	05300	0	0	0	53.00
54.00	05400	346,684	0	346,684	54.00
54.01	05401	40,223	0	40,223	54.01
55.00	05500	89,506	0	89,506	55.00
56.00	05600	63,135	0	63,135	56.00
57.00	05700	81,791	0	81,791	57.00
58.00	05800	33,660	0	33,660	58.00
59.00	05900	86,252	0	86,252	59.00
60.00	06000	215,956	0	215,956	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	8,479	0	8,479	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	67,698	0	67,698	65.00
66.00	06600	82,414	0	82,414	66.00
67.00	06700	69,064	0	69,064	67.00
68.00	06800	12,946	0	12,946	68.00
69.00	06900	7,950	0	7,950	69.00
69.01	06901	2,234	0	2,234	69.01
70.00	07000	19,010	0	19,010	70.00
71.00	07100	139,731	0	139,731	71.00
72.00	07200	158,089	0	158,089	72.00
73.00	07300	160,437	0	160,437	73.00
74.00	07400	36,544	0	36,544	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	482,096	0	482,096	90.00
91.00	09100	242,509	0	242,509	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	6,492	0	6,492	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		5,924,187	0	5,924,187	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	11,721	0	11,721	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	239,959	0	239,959	192.00
192.01	19201	OTHER NON-REIMBURSABLE	31,644	0	31,644	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	55,182	0	55,182	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	49,767	0	49,767	200.00
201.00		Negative Cost Centers	3,137	0	3,137	201.00
202.00		TOTAL (sum lines 118-201)	6,315,597	0	6,315,597	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,410,133				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,906	139,996,708			4.00
5.01 00550	DATA PROCESSING	9,190	4,144,273	100		5.01
5.02 00560	PURCHASING RECEIVING AND STORES	7,332	931,211	0	38,660,932	5.02
5.03 00570	ADMITTING	9,717	2,054,640	0	45,114	1,117,517,073
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	30,646	2,032,776	0	21,928	0
5.05 00590	OTHER A&G	99,579	10,522,518	100	76,086	0
5.06 00592	PATIENT TRANSPORTATION	0	568,357	0	2,161	0
7.00 00700	OPERATION OF PLANT	299,329	3,462,001	0	331,695	0
8.00 00800	LAUNDRY & LINEN SERVICE	17,825	0	0	2,174	0
9.00 00900	HOUSEKEEPING	20,635	4,635,956	0	475,601	0
10.00 01000	DIETARY	18,848	2,059,722	0	405,603	0
11.00 01100	CAFETERIA	13,177	1,336,379	0	517	0
13.00 01300	NURSING ADMINISTRATION	6,350	2,536,624	0	14,244	0
14.00 01400	CENTRAL SERVICES & SUPPLY	35,843	541,101	0	649,390	0
15.00 01500	PHARMACY	18,957	0	0	102,452	0
16.00 01600	MEDICAL RECORDS & LIBRARY	11,307	2,003,145	0	10,696	0
17.00 01700	SOCIAL SERVICE	1,629	505,798	0	0	0
17.01 01701	STAFF EDUCATION	11,147	0	0	0	0
17.02 01702	MEDICAL EDUCATION	374	70,791	0	362	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,467	0	0	0	0
23.00 02300	PARAMED ED PROGRAM	3,364	510,154	0	5,532	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	313,217	30,321,025	0	1,983,295	89,915,547
31.00 03100	INTENSIVE CARE UNIT	19,864	6,216,119	0	609,808	15,886,740
31.01 03101	NEONATAL ICU	2,258	2,265,167	0	4,138	5,520,897
40.00 04000	SUBPROVIDER - I PF	3,972	677,994	0	530	1,989,517
41.00 04100	SUBPROVIDER - I RF	31,243	3,044,778	0	96,471	7,787,570
43.00 04300	NURSERY	24,424	617,742	0	127,902	1,847,930
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	59,647	4,188,291	0	838,798	152,248,055
50.01 05001	ENDOSCOPY	0	1,214,789	0	687,933	21,205,406
51.00 05100	RECOVERY ROOM	14,546	948,738	0	36,995	9,646,080
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,003	2,602,118	0	110,489	7,320,682
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	53,059	2,295,466	0	161,859	33,127,540
54.01 05401	RADIOLOGY - ULTRASOUND	5,054	1,301,433	0	158,115	14,719,455
55.00 05500	RADIOLOGY-THERAPEUTIC	13,485	519,054	0	27,309	15,715,782
56.00 05600	RADIOISOTOPE	9,043	495,956	0	705,442	11,699,610
57.00 05700	CT SCAN	8,563	1,026,854	0	309,782	95,438,848
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,205	405,574	0	80,849	24,894,009
59.00 05900	CARDIAC CATHETERIZATION	8,393	1,999,303	0	405,023	86,817,817
60.00 06000	LABORATORY	23,518	3,513,382	0	2,750,177	128,468,353
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1,157,666	0	257,256	2,000,414
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	7,766	2,351,478	0	454,700	43,724,544
66.00 06600	PHYSICAL THERAPY	12,270	1,416,643	0	11,310	7,094,482
67.00 06700	OCCUPATIONAL THERAPY	10,545	1,068,842	0	15,069	5,353,626
68.00 06800	SPEECH PATHOLOGY	1,796	397,185	0	6,864	1,872,032
69.00 06900	ELECTROCARDIOLOGY	0	613,329	0	16,695	17,555,773
69.01 06901	CARDIAC REHAB	0	376,805	0	7,087	598,569
70.00 07000	ELECTROENCEPHALOGRAPHY	0	864,514	0	0	38,182,951
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,196,174	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,785,480	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,662	428,980	0	508,539	124,628,228
74.00 07400	RENAL DIALYSIS	4,383	0	0	12,868	6,923,559
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	76,181	2,253,687	0	70,795	21,068,208
91.00 09100	EMERGENCY	27,063	6,425,294	0	1,481,087	77,459,868
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	1,832,997	0	87,934	3,382,710
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,369,167	120,756,649	100	38,150,328	1,074,094,802

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)			
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00	5.01	5.02	5.03			
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	56,241	0	174,319	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,711	15,895,269	0	335,610	38,181,825	192.00
192.01	19201	OTHER NON-REIMBURSABLE	3,457	3,125,267	0	675	5,240,446	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	8,997	163,282	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,315,597	25,265,620	15,280,141	3,391,974	3,005,015	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.478724	0.180473	152,801.410000	0.087736	0.002689	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		26,451	41,942	33,014	43,947	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000189	419.420000	0.000854	0.000039	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,117,517,073					5.04
5.05	00590	OTHER A&G	0	-40,086,003	274,584,159			5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	736,056	53,119		5.06
7.00	00700	OPERATION OF PLANT	0	0	16,715,285	0	948,434	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,524,396	0	17,825	8.00
9.00	00900	HOUSEKEEPING	0	0	7,008,011	0	20,635	9.00
10.00	01000	DIETARY	0	0	4,635,537	0	18,848	10.00
11.00	01100	CAFETERIA	0	0	2,132,630	0	13,177	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,495,325	0	6,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,713,037	0	35,843	14.00
15.00	01500	PHARMACY	0	0	75,841	0	18,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,392,391	1	11,307	16.00
17.00	01700	SOCIAL SERVICE	0	0	604,377	0	1,629	17.00
17.01	01701	STAFF EDUCATION	0	0	49,924	0	11,147	17.01
17.02	01702	MEDICAL EDUCATION	0	0	106,903	0	374	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	210,204	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	29,594	0	4,467	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	307,781	0	3,364	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	89,915,547	0	43,552,554	22,867	313,217	30.00
31.00	03100	INTENSIVE CARE UNIT	15,886,740	0	8,859,917	410	19,864	31.00
31.01	03101	NEONATAL ICU	5,520,897	0	2,908,043	0	2,258	31.01
40.00	04000	SUBPROVIDER - I/PF	1,989,517	0	899,344	36	3,972	40.00
41.00	04100	SUBPROVIDER - I/RF	7,787,570	0	4,219,609	608	31,243	41.00
43.00	04300	NURSERY	1,847,930	0	1,093,918	0	24,424	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	152,248,055	0	9,974,497	0	59,647	50.00
50.01	05001	ENDOSCOPY	21,205,406	0	3,468,930	1,500	0	50.01
51.00	05100	RECOVERY ROOM	9,646,080	0	1,366,110	5	14,546	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,320,682	0	3,687,344	370	7,003	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,127,540	0	5,198,961	5,885	53,059	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	14,719,455	0	2,071,647	5,624	5,054	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	15,715,782	0	1,698,126	439	13,485	55.00
56.00	05600	RADIOISOTOPE	11,699,610	0	1,684,464	2,821	9,043	56.00
57.00	05700	CT SCAN	95,438,848	0	2,730,210	7,465	8,563	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,894,009	0	791,669	2,642	4,205	58.00
59.00	05900	CARDIAC CATHETERIZATION	86,817,817	0	4,988,356	1,575	8,393	59.00
60.00	06000	LABORATORY	128,468,353	0	11,953,524	1	23,518	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,000,414	0	1,623,580	0	385	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	43,724,544	0	3,949,708	107	7,766	65.00
66.00	06600	PHYSICAL THERAPY	7,094,482	0	1,903,379	0	12,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,353,626	0	1,486,909	0	10,545	67.00
68.00	06800	SPEECH PATHOLOGY	1,872,032	0	535,439	0	1,796	68.00
69.00	06900	ELECTROCARDIOLOGY	17,555,773	0	1,117,816	236	0	69.00
69.01	06901	CARDIAC REHAB	598,569	0	801,634	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	38,182,951	0	1,496,602	441	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,178,481	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,907,244	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,628,228	0	18,441,224	0	1,662	73.00
74.00	07400	RENAL DIALYSIS	6,923,559	0	1,853,954	1	4,383	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,068,208	0	5,327,977	9	76,181	90.00
91.00	09100	EMERGENCY	77,459,868	0	10,691,077	76	27,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,382,710	0	2,528,398	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,074,094,802	-40,086,003	232,727,937	53,119	907,468	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	277,741	0	1,801	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,181,825	0	36,137,667	0	26,711	192.00
192.01	19201	OTHER NON-REIMBURSABLE	5,240,446	0	5,159,147	0	3,457	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	281,667	0	8,997	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,271,826		40,086,003	843,511	19,155,516	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003823		0.145988	15.879648	20.196994	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	137,658		489,983	1,422	1,371,369	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000123		0.001784	0.026770	1.445930	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00570	ADMITTING					5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04	
5.05	00590	OTHER A&G					5.05	
5.06	00592	PATIENT TRANSPORTATION					5.06	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,201,188				8.00	
9.00	00900	HOUSEKEEPING	0	909,974			9.00	
10.00	01000	DIETARY	0	18,848	388,582		10.00	
11.00	01100	CAFETERIA	0	13,177	0	2,720,767	11.00	
13.00	01300	NURSING ADMINISTRATION	0	6,350	0	59,599	1,849,640	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,313	35,843	0	32,226	0	14.00
15.00	01500	PHARMACY	13	18,957	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,307	0	85,398	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,629	0	17,280	17,280	17.00
17.01	01701	STAFF EDUCATION	0	11,147	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	374	0	2,095	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,467	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	3,364	0	19,337	19,337	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,043,479	313,217	265,013	1,000,091	1,000,091	30.00
31.00	03100	INTENSIVE CARE UNIT	55,240	19,864	53,319	161,355	161,355	31.00
31.01	03101	NEONATAL ICU	48,761	2,258	0	53,539	53,539	31.01
40.00	04000	SUBPROVIDER - I PF	0	3,972	0	19,892	19,892	40.00
41.00	04100	SUBPROVIDER - I RF	0	31,243	35,972	100,696	100,696	41.00
43.00	04300	NURSERY	45,328	24,424	0	15,526	15,526	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	219,730	59,647	0	127,091	127,091	50.00
50.01	05001	ENDOSCOPY	29,200	0	7	35,998	35,998	50.01
51.00	05100	RECOVERY ROOM	57,518	14,546	15,882	24,331	24,331	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,140	7,003	0	74,646	74,646	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,063	53,059	0	78,607	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	12,397	5,054	0	30,001	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,312	13,485	0	12,920	0	55.00
56.00	05600	RADIOISOTOPE	26,806	9,043	0	11,710	0	56.00
57.00	05700	CT SCAN	16,839	8,563	0	29,547	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,732	4,205	0	10,740	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,099	8,393	3,656	50,454	0	59.00
60.00	06000	LABORATORY	0	23,518	0	116,386	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	385	0	62,442	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,236	7,766	0	75,309	0	65.00
66.00	06600	PHYSICAL THERAPY	26,541	12,270	0	39,578	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,545	0	27,626	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,796	777	9,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,616	0	0	22,352	0	69.00
69.01	06901	CARDIAC REHAB	4,262	0	0	11,476	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	19	23,824	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,662	0	10,361	0	73.00
74.00	07400	RENAL DIALYSIS	101,245	4,383	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	46,057	76,181	0	65,021	0	90.00
91.00	09100	EMERGENCY	234,787	27,063	13,937	199,858	199,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,188,714	869,008	388,582	2,716,644	1,849,640	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,801	0	4,123	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,474	26,711	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	3,457	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	8,997	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,106,951	8,447,862	5,867,921	2,832,434	4,254,848	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.957188	9.283630	15.100856	1.041042	2.300365	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,329	136,039	123,491	84,097	47,140	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.049214	0.149498	0.317799	0.030909	0.025486	205.00

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet B-1	
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Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)			
	14.00	15.00	16.00	17.00	17.01			
GENERAL SERVICE COST CENTERS								
1.00 00100	CAP REL COSTS-BLDG & FIXT							1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01 00550	DATA PROCESSING							5.01
5.02 00560	PURCHASING RECEIVING AND STORES							5.02
5.03 00570	ADMITTING							5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05 00590	OTHER A&G							5.05
5.06 00592	PATIENT TRANSPORTATION							5.06
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	23,981,654						14.00
15.00 01500	PHARMACY	0	13,537,166					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	1,073,464,141				16.00
17.00 01700	SOCIAL SERVICE	0	0	0	801			17.00
17.01 01701	STAFF EDUCATION	0	0	0	0	119,051		17.01
17.02 01702	MEDICAL EDUCATION	0	0	0	0	0		17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0		22.00
23.00 02300	PARAMED ED PROGRAM	0	0	0	0	56		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	0	0	93,208,923	620	57,449		30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	15,276,741	0	8,663		31.00
31.01 03101	NEONATAL ICU	0	0	5,478,673	0	4,019		31.01
40.00 04000	SUBPROVIDER - I PF	0	0	1,984,549	0	1,020		40.00
41.00 04100	SUBPROVIDER - I RF	0	0	7,786,843	142	8,368		41.00
43.00 04300	NURSERY	0	0	1,790,154	0	543		43.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	0	0	134,228,783	0	6,220		50.00
50.01 05001	ENDOSCOPY	0	0	18,482,384	0	793		50.01
51.00 05100	RECOVERY ROOM	0	0	9,646,080	0	1,166		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	5,224,893	0	3,906		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	33,036,446	0	1,086		54.00
54.01 05401	RADIOLOGY - ULTRASOUND	0	0	14,458,276	0	586		54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	15,637,878	0	351		55.00
56.00 05600	RADIOISOTOPE	0	0	11,699,610	0	20		56.00
57.00 05700	CT SCAN	0	0	94,456,433	0	431		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	24,887,595	0	1		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	65,447,409	0	3,057		59.00
60.00 06000	LABORATORY	0	1,826,984	122,907,801	0	632		60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0		60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0		61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	7,454,409	0	24		62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0		63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	0	0	37,427,751	0	668		65.00
66.00 06600	PHYSICAL THERAPY	0	0	7,094,482	0	35		66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	5,313,169	0	72		67.00
68.00 06800	SPEECH PATHOLOGY	0	0	1,867,683	0	51		68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	17,555,773	0	702		69.00
69.01 06901	CARDIAC REHAB	0	0	596,633	0	39		69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	828,078	28,551,810	0	553		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,196,174	0	44,583,611	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	12,785,480	0	30,397,573	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	10,537,184	122,821,796	0	379		73.00
74.00 07400	RENAL DIALYSIS	0	0	6,915,420	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
90.00 09000	CLINIC	0	0	20,497,887	0	359		90.00
91.00 09100	EMERGENCY	0	0	63,412,996	39	15,932		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00 10100	HOME HEALTH AGENCY	0	24,627	3,333,677	0	997		101.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,981,654	13,216,873	1,073,464,141	801	118,178		118.00
NONREIMBURSABLE COST CENTERS								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
			14.00	15.00	16.00	17.00	17.01	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	320,293	0	0	873	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,222,603	645,789	4,309,895	798,372	385,833	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.176076	0.047705	0.004015	996.719101	3.240905	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	225,405	115,370	77,760	12,043	67,797	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009399	0.008291	0.000072	15.034956	0.569479	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.02	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00570 ADMINITING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590 OTHER A&G						5.05
5.06 00592 PATIENT TRANSPORTATION						5.06
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						17.00
17.01 01701 STAFF EDUCATION						17.01
17.02 01702 MEDICAL EDUCATION	100					17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100			22.00
23.00 02300 PARAMED PROGRAM	0			100		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01 03101 NEONATAL ICU	0	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	100	100	100	100	100	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	100	100	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PROGRAM (ASSIGNED TIME)			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
		17.02	21.00				22.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	135,717	240,891	165,604	516,680	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,357.170000	2,408.910000	1,656.040000	5,166.800000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,541	375	27,186	22,206	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	25.410000	3.750000	271.860000	222.060000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 10/17/2017 3:54 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		69,028,502	0	69,028,502	30.00
31.00	03100 INTENSIVE CARE UNIT		12,232,075	0	12,232,075	31.00
31.01	03101 NEONATAL ICU		3,659,739	0	3,659,739	31.01
40.00	04000 SUBPROVIDER - I PF		1,226,047	0	1,226,047	40.00
41.00	04100 SUBPROVIDER - I RF		6,845,932	0	6,845,932	41.00
43.00	04300 NURSERY		2,077,863	0	2,077,863	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		14,383,096	0	14,383,096	50.00
50.01	05001 ENDOSCOPY		4,224,288	0	4,224,288	50.01
51.00	05100 RECOVERY ROOM		2,413,146	0	2,413,146	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,768,076	0	4,768,076	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,903,540	0	7,903,540	54.00
54.01	05401 RADIOLOGY - ULTRASOUND		2,715,432	0	2,715,432	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		2,431,093	0	2,431,093	55.00
56.00	05600 RADIOISOTOPE		2,326,653	0	2,326,653	56.00
57.00	05700 CT SCAN		3,927,291	0	3,927,291	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,190,715	0	1,190,715	58.00
59.00	05900 CARDIAC CATHETERIZATION		6,415,489	0	6,415,489	59.00
60.00	06000 LABORATORY		15,095,778	0	15,095,778	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1,966,965	0	1,966,965	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,990,898	0	4,990,898	65.00
66.00	06600 PHYSICAL THERAPY	0	2,638,180	0	2,638,180	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,065,178	0	2,065,178	67.00
68.00	06800 SPEECH PATHOLOGY	0	695,666	0	695,666	68.00
69.00	06900 ELECTROCARDIOLOGY		1,392,858	0	1,392,858	69.00
69.01	06901 CARDIAC REHAB		937,211	0	937,211	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		1,903,111	0	1,903,111	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		16,106,774	0	16,106,774	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		18,310,806	0	18,310,806	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		22,190,236	0	22,190,236	73.00
74.00	07400 RENAL DIALYSIS		2,378,513	0	2,378,513	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		8,547,041	0	8,547,041	90.00
91.00	09100 EMERGENCY		15,151,396	0	15,151,396	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		12,228,475	0	12,228,475	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		2,915,305	0	2,915,305	101.00
200.00	Subtotal (see instructions)	0	277,283,368	0	277,283,368	200.00
201.00	Less Observation Beds		12,228,475	0	12,228,475	201.00
202.00	Total (see instructions)	0	265,054,893	0	265,054,893	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 10/17/2017 3:54 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	68,931,387		68,931,387				30.00
31.00	03100	INTENSIVE CARE UNIT	15,276,741		15,276,741				31.00
31.01	03101	NEONATAL ICU	5,478,673		5,478,673				31.01
40.00	04000	SUBPROVIDER - I PF	1,984,549		1,984,549				40.00
41.00	04100	SUBPROVIDER - I RF	7,786,843		7,786,843				41.00
43.00	04300	NURSERY	1,790,154		1,790,154				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	85,877,373	48,351,410	134,228,783	0.107154	0.000000		50.00
50.01	05001	ENDOSCOPY	5,025,533	13,456,851	18,482,384	0.228558	0.000000		50.01
51.00	05100	RECOVERY ROOM	4,984,361	4,661,719	9,646,080	0.250169	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,007,050	2,217,843	5,224,893	0.912569	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,444,230	23,592,216	33,036,446	0.239237	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	4,857,278	9,600,998	14,458,276	0.187812	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,118,514	14,519,364	15,637,878	0.155462	0.000000		55.00
56.00	05600	RADIOISOTOPE	5,702,439	5,997,171	11,699,610	0.198866	0.000000		56.00
57.00	05700	CT SCAN	37,220,209	57,236,224	94,456,433	0.041578	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,821,392	15,066,203	24,887,595	0.047844	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	31,007,460	34,439,949	65,447,409	0.098025	0.000000		59.00
60.00	06000	LABORATORY	57,764,300	65,143,501	122,907,801	0.122822	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,798,395	1,656,014	7,454,409	0.263866	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	33,369,261	4,058,490	37,427,751	0.133348	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,899,796	194,686	7,094,482	0.371864	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,223,402	89,767	5,313,169	0.388690	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,737,836	129,847	1,867,683	0.372475	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	10,237,381	7,318,392	17,555,773	0.079339	0.000000		69.00
69.01	06901	CARDIAC REHAB	183,992	412,641	596,633	1.570833	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	10,333,766	18,218,044	28,551,810	0.066655	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,058,802	19,524,809	44,583,611	0.361271	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,800,442	11,597,131	30,397,573	0.602377	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,579,247	19,242,549	122,821,796	0.180670	0.000000		73.00
74.00	07400	RENAL DIALYSIS	6,578,285	337,135	6,915,420	0.343943	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	470,255	20,027,632	20,497,887	0.416972	0.000000		90.00
91.00	09100	EMERGENCY	16,516,235	46,896,761	63,412,996	0.238932	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,201,180	17,076,356	24,277,536	0.503695	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,333,677	3,333,677				101.00
200.00		Subtotal (see instructions)	609,066,761	464,397,380	1,073,464,141				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	609,066,761	464,397,380	1,073,464,141				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 10/17/2017 3:54 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL ICU			31.01
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107154		50.00
50.01	05001	ENDOSCOPY	0.228558		50.01
51.00	05100	RECOVERY ROOM	0.250169		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462		55.00
56.00	05600	RADIOISOTOPE	0.198866		56.00
57.00	05700	CT SCAN	0.041578		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025		59.00
60.00	06000	LABORATORY	0.122822		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.133348		65.00
66.00	06600	PHYSICAL THERAPY	0.371864		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690		67.00
68.00	06800	SPEECH PATHOLOGY	0.372475		68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339		69.00
69.01	06901	CARDIAC REHAB	1.570833		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670		73.00
74.00	07400	RENAL DIALYSIS	0.343943		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416972		90.00
91.00	09100	EMERGENCY	0.238932		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

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

Worksheet C
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	69,028,502		69,028,502	0	69,028,502	30.00
31.00	03100 INTENSIVE CARE UNIT	12,232,075		12,232,075	0	12,232,075	31.00
31.01	03101 NEONATAL ICU	3,659,739		3,659,739	0	3,659,739	31.01
40.00	04000 SUBPROVIDER - I PF	1,226,047		1,226,047	0	1,226,047	40.00
41.00	04100 SUBPROVIDER - I RF	6,845,932		6,845,932	0	6,845,932	41.00
43.00	04300 NURSERY	2,077,863		2,077,863	0	2,077,863	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,383,096		14,383,096	0	14,383,096	50.00
50.01	05001 ENDOSCOPY	4,224,288		4,224,288	0	4,224,288	50.01
51.00	05100 RECOVERY ROOM	2,413,146		2,413,146	0	2,413,146	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,768,076		4,768,076	0	4,768,076	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,903,540		7,903,540	0	7,903,540	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	2,715,432		2,715,432	0	2,715,432	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	2,431,093		2,431,093	0	2,431,093	55.00
56.00	05600 RADIOISOTOPE	2,326,653		2,326,653	0	2,326,653	56.00
57.00	05700 CT SCAN	3,927,291		3,927,291	0	3,927,291	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,190,715		1,190,715	0	1,190,715	58.00
59.00	05900 CARDIAC CATHETERIZATION	6,415,489		6,415,489	0	6,415,489	59.00
60.00	06000 LABORATORY	15,095,778		15,095,778	0	15,095,778	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,966,965		1,966,965	0	1,966,965	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,990,898	0	4,990,898	0	4,990,898	65.00
66.00	06600 PHYSICAL THERAPY	2,638,180	0	2,638,180	0	2,638,180	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,065,178	0	2,065,178	0	2,065,178	67.00
68.00	06800 SPEECH PATHOLOGY	695,666	0	695,666	0	695,666	68.00
69.00	06900 ELECTROCARDIOLOGY	1,392,858		1,392,858	0	1,392,858	69.00
69.01	06901 CARDIAC REHAB	937,211		937,211	0	937,211	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	1,903,111		1,903,111	0	1,903,111	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,106,774		16,106,774	0	16,106,774	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,310,806		18,310,806	0	18,310,806	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,190,236		22,190,236	0	22,190,236	73.00
74.00	07400 RENAL DIALYSIS	2,378,513		2,378,513	0	2,378,513	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	8,547,041		8,547,041	0	8,547,041	90.00
91.00	09100 EMERGENCY	15,151,396		15,151,396	0	15,151,396	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12,228,475		12,228,475	0	12,228,475	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	2,915,305		2,915,305	0	2,915,305	101.00
200.00	Subtotal (see instructions)	277,283,368	0	277,283,368	0	277,283,368	200.00
201.00	Less Observation Beds	12,228,475		12,228,475	0	12,228,475	201.00
202.00	Total (see instructions)	265,054,893	0	265,054,893	0	265,054,893	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet C Part I Date/Time Prepared: 10/17/2017 3:54 pm		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	68,931,387		68,931,387				30.00
31.00	03100	INTENSIVE CARE UNIT	15,276,741		15,276,741				31.00
31.01	03101	NEONATAL ICU	5,478,673		5,478,673				31.01
40.00	04000	SUBPROVIDER - I/PF	1,984,549		1,984,549				40.00
41.00	04100	SUBPROVIDER - I/RP	7,786,843		7,786,843				41.00
43.00	04300	NURSERY	1,790,154		1,790,154				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	85,877,373	48,351,410	134,228,783	0.107154	0.000000		50.00
50.01	05001	ENDOSCOPY	5,025,533	13,456,851	18,482,384	0.228558	0.000000		50.01
51.00	05100	RECOVERY ROOM	4,984,361	4,661,719	9,646,080	0.250169	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,007,050	2,217,843	5,224,893	0.912569	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,444,230	23,592,216	33,036,446	0.239237	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	4,857,278	9,600,998	14,458,276	0.187812	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,118,514	14,519,364	15,637,878	0.155462	0.000000		55.00
56.00	05600	RADIOISOTOPE	5,702,439	5,997,171	11,699,610	0.198866	0.000000		56.00
57.00	05700	CT SCAN	37,220,209	57,236,224	94,456,433	0.041578	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,821,392	15,066,203	24,887,595	0.047844	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	31,007,460	34,439,949	65,447,409	0.098025	0.000000		59.00
60.00	06000	LABORATORY	57,764,300	65,143,501	122,907,801	0.122822	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,798,395	1,656,014	7,454,409	0.263866	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	33,369,261	4,058,490	37,427,751	0.133348	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,899,796	194,686	7,094,482	0.371864	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,223,402	89,767	5,313,169	0.388690	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,737,836	129,847	1,867,683	0.372475	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	10,237,381	7,318,392	17,555,773	0.079339	0.000000		69.00
69.01	06901	CARDIAC REHAB	183,992	412,641	596,633	1.570833	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	10,333,766	18,218,044	28,551,810	0.066655	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,058,802	19,524,809	44,583,611	0.361271	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,800,442	11,597,131	30,397,573	0.602377	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,579,247	19,242,549	122,821,796	0.180670	0.000000		73.00
74.00	07400	RENAL DIALYSIS	6,578,285	337,135	6,915,420	0.343943	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	470,255	20,027,632	20,497,887	0.416972	0.000000		90.00
91.00	09100	EMERGENCY	16,516,235	46,896,761	63,412,996	0.238932	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,201,180	17,076,356	24,277,536	0.503695	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,333,677	3,333,677				101.00
200.00		Subtotal (see instructions)	609,066,761	464,397,380	1,073,464,141				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	609,066,761	464,397,380	1,073,464,141				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31.01	03101 NEONATAL ICU				31.01
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
50.01	05001 ENDOSCOPY	0.000000			50.01
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000			54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901 CARDIAC REHAB	0.000000			69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,243,677	0	2,243,677	97,645	22.98	30.00
31.00	INTENSIVE CARE UNIT	175,540		175,540	8,379	20.95	31.00
31.01	NEONATAL ICU	28,332		28,332	3,028	9.36	31.01
40.00	SUBPROVIDER - IPF	28,028	0	28,028	1,506	18.61	40.00
41.00	SUBPROVIDER - IRF	223,809	0	223,809	10,538	21.24	41.00
43.00	NURSERY	154,376		154,376	2,874	53.71	43.00
200.00	Total (Lines 30-199)	2,853,762		2,853,762	123,970		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	35,763	821,834	30.00
31.00	INTENSIVE CARE UNIT	4,163	87,215	31.00
31.01	NEONATAL ICU	0	0	31.01
40.00	SUBPROVIDER - IPF	546	10,161	40.00
41.00	SUBPROVIDER - IRF	7,566	160,702	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (Lines 30-199)	48,038	1,079,912	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 10/17/2017 3:54 pm
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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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	438,493	134,228,783	0.003267	35,706,610	116,653	50.00
50.01	05001	ENDOSCOPY	15,733	18,482,384	0.000851	2,434,800	2,072	50.01
51.00	05100	RECOVERY ROOM	103,174	9,646,080	0.010696	1,687,787	18,053	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,125	5,224,893	0.011507	42,766	492	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,684	33,036,446	0.010494	4,640,336	48,696	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	40,223	14,458,276	0.002782	2,216,611	6,167	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	89,506	15,637,878	0.005724	417,795	2,391	55.00
56.00	05600	RADIOISOTOPE	63,135	11,699,610	0.005396	2,650,861	14,304	56.00
57.00	05700	CT SCAN	81,791	94,456,433	0.000866	15,623,694	13,530	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,660	24,887,595	0.001352	4,215,528	5,699	58.00
59.00	05900	CARDIAC CATHETERIZATION	86,252	65,447,409	0.001318	14,857,865	19,583	59.00
60.00	06000	LABORATORY	215,956	122,907,801	0.001757	25,950,994	45,596	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,479	7,454,409	0.001137	2,112,164	2,402	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	67,698	37,427,751	0.001809	16,049,207	29,033	65.00
66.00	06600	PHYSICAL THERAPY	82,414	7,094,482	0.011617	1,723,322	20,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,064	5,313,169	0.012999	890,959	11,582	67.00
68.00	06800	SPEECH PATHOLOGY	12,946	1,867,683	0.006932	714,579	4,953	68.00
69.00	06900	ELECTROCARDIOLOGY	7,950	17,555,773	0.000453	4,544,354	2,059	69.00
69.01	06901	CARDIAC REHAB	2,234	596,633	0.003744	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	19,010	28,551,810	0.000666	1,859,054	1,238	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,731	44,583,611	0.003134	9,438,949	29,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,089	30,397,573	0.005201	8,340,651	43,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,437	122,821,796	0.001306	45,506,121	59,431	73.00
74.00	07400	RENAL DIALYSIS	36,544	6,915,420	0.005284	3,877,028	20,486	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	482,096	20,497,887	0.023519	178,857	4,207	90.00
91.00	09100	EMERGENCY	242,509	63,412,996	0.003824	9,949,424	38,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	397,474	24,277,536	0.016372	0	0	92.00
200.00		Total (Lines 50-199)	3,461,407	968,882,117		215,630,316	559,656	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description	Title XVIII				Hospital	
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS	
	1.00	2.00	3.00	4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
	6.00	7.00	8.00	9.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	97,645	0.00	35,763	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,379	0.00	4,163	0	31.00
31.01	03101	NEONATAL ICU	3,028	0.00	0	0	31.01
40.00	04000	SUBPROVIDER - I PF	1,506	0.00	546	0	40.00
41.00	04100	SUBPROVIDER - I RF	10,538	0.00	7,566	0	41.00
43.00	04300	NURSERY	2,874	0.00	0	0	43.00
200.00		Total (lines 30-199)	123,970		48,038	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	516,680	0	0	516,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	516,680	0	0	516,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	134,228,783	0.000000	0.000000	35,706,610	50.00
50.01	05001	ENDOSCOPY	0	18,482,384	0.000000	0.000000	2,434,800	50.01
51.00	05100	RECOVERY ROOM	0	9,646,080	0.000000	0.000000	1,687,787	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,224,893	0.000000	0.000000	42,766	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,036,446	0.000000	0.000000	4,640,336	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	14,458,276	0.000000	0.000000	2,216,611	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,637,878	0.000000	0.000000	417,795	55.00
56.00	05600	RADIOISOTOPE	0	11,699,610	0.000000	0.000000	2,650,861	56.00
57.00	05700	CT SCAN	0	94,456,433	0.000000	0.000000	15,623,694	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	24,887,595	0.000000	0.000000	4,215,528	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	65,447,409	0.000000	0.000000	14,857,865	59.00
60.00	06000	LABORATORY	0	122,907,801	0.000000	0.000000	25,950,994	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,454,409	0.000000	0.000000	2,112,164	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	37,427,751	0.000000	0.000000	16,049,207	65.00
66.00	06600	PHYSICAL THERAPY	0	7,094,482	0.000000	0.000000	1,723,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,313,169	0.000000	0.000000	890,959	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,867,683	0.000000	0.000000	714,579	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,555,773	0.000000	0.000000	4,544,354	69.00
69.01	06901	CARDIAC REHAB	0	596,633	0.000000	0.000000	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,551,810	0.000000	0.000000	1,859,054	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,583,611	0.000000	0.000000	9,438,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,397,573	0.000000	0.000000	8,340,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	122,821,796	0.000000	0.000000	45,506,121	73.00
74.00	07400	RENAL DIALYSIS	0	6,915,420	0.000000	0.000000	3,877,028	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	20,497,887	0.000000	0.000000	178,857	90.00
91.00	09100	EMERGENCY	516,680	63,412,996	0.008148	0.008148	9,949,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	24,277,536	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	516,680	968,882,117			215,630,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	14,074,841	0		50.00
50.01	05001 ENDOSCOPY	0	4,816,930	0		50.01
51.00	05100 RECOVERY ROOM	0	1,707,733	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	391,701	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,494,877	0		54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	2,066,287	0		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	5,964,251	0		55.00
56.00	05600 RADIOISOTOPE	0	2,062,572	0		56.00
57.00	05700 CT SCAN	0	13,621,405	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4,091,792	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	14,908,893	0		59.00
60.00	06000 LABORATORY	0	7,259,136	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	213,746	0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	709,480	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	123	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,824,811	0		69.00
69.01	06901 CARDIAC REHAB	0	145,425	0		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,395,742	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,036,322	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,047,402	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,186,264	0		73.00
74.00	07400 RENAL DIALYSIS	0	228,680	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	5,837,079	0		90.00
91.00	09100 EMERGENCY	81,068	8,995,217	73,293		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,859,883	0		92.00
200.00	Total (Lines 50-199)	81,068	120,940,592	73,293		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.107154	14,074,841	0	0	1,508,176	50.00
50.01	05001	ENDOSCOPY	0.228558	4,816,930	0	0	1,100,948	50.01
51.00	05100	RECOVERY ROOM	0.250169	1,707,733	0	0	427,222	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	391,701	0	0	357,454	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	7,494,877	95	0	1,793,052	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	2,066,287	0	0	388,073	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	5,964,251	0	0	927,214	55.00
56.00	05600	RADIOISOTOPE	0.198866	2,062,572	0	0	410,175	56.00
57.00	05700	CT SCAN	0.041578	13,621,405	0	0	566,351	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	4,091,792	0	0	195,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	14,908,893	0	0	1,461,444	59.00
60.00	06000	LABORATORY	0.122822	7,259,136	0	0	891,582	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	213,746	0	0	56,400	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	709,480	0	0	94,608	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	123	0	0	48	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	1,824,811	0	0	144,779	69.00
69.01	06901	CARDIAC REHAB	1.570833	145,425	0	0	228,438	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	2,395,742	0	0	159,688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	5,036,322	0	0	1,819,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	5,047,402	0	0	3,040,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	9,186,264	0	41,517	1,659,682	73.00
74.00	07400	RENAL DIALYSIS	0.343943	228,680	0	0	78,653	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.416972	5,837,079	0	0	2,433,899	90.00
91.00	09100	EMERGENCY	0.238932	8,995,217	0	0	2,149,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	2,859,883	0	0	1,440,509	92.00
200.00		Subtotal (see instructions)		120,940,592	95	41,517	23,333,324	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		120,940,592	95	41,517	23,333,324	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,501	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	23	7,501	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	23	7,501	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	438,493	134,228,783	0.003267	5,100	17	50.00
50.01	05001 ENDOSCOPY	15,733	18,482,384	0.000851	4,586	4	50.01
51.00	05100 RECOVERY ROOM	103,174	9,646,080	0.010696	888	9	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	60,125	5,224,893	0.011507	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	346,684	33,036,446	0.010494	6,719	71	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	40,223	14,458,276	0.002782	2,319	6	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	89,506	15,637,878	0.005724	0	0	55.00
56.00	05600 RADIOISOTOPE	63,135	11,699,610	0.005396	2,127	11	56.00
57.00	05700 CT SCAN	81,791	94,456,433	0.000866	60,200	52	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	33,660	24,887,595	0.001352	4,794	6	58.00
59.00	05900 CARDIAC CATHETERIZATION	86,252	65,447,409	0.001318	68,203	90	59.00
60.00	06000 LABORATORY	215,956	122,907,801	0.001757	138,560	243	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	8,479	7,454,409	0.001137	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	67,698	37,427,751	0.001809	9,247	17	65.00
66.00	06600 PHYSICAL THERAPY	82,414	7,094,482	0.011617	8,108	94	66.00
67.00	06700 OCCUPATIONAL THERAPY	69,064	5,313,169	0.012999	5,210	68	67.00
68.00	06800 SPEECH PATHOLOGY	12,946	1,867,683	0.006932	1,570	11	68.00
69.00	06900 ELECTROCARDIOLOGY	7,950	17,555,773	0.000453	10,352	5	69.00
69.01	06901 CARDIAC REHAB	2,234	596,633	0.003744	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	19,010	28,551,810	0.000666	834	1	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	139,731	44,583,611	0.003134	15,806	50	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	158,089	30,397,573	0.005201	794	4	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	160,437	122,821,796	0.001306	173,598	227	73.00
74.00	07400 RENAL DIALYSIS	36,544	6,915,420	0.005284	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	482,096	20,497,887	0.023519	0	0	90.00
91.00	09100 EMERGENCY	242,509	63,412,996	0.003824	76,964	294	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	24,277,536	0.000000	0	0	92.00
200.00	Total (lines 50-199)	3,063,933	968,882,117		595,979	1,280	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
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	Title XVIII	Subprovider - IPF	PPS
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	516,680	0	516,680	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	516,680	0	516,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	134,228,783	0.000000	0.000000	5,100	50.00
50.01	05001 ENDOSCOPY	0	18,482,384	0.000000	0.000000	4,586	50.01
51.00	05100 RECOVERY ROOM	0	9,646,080	0.000000	0.000000	888	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,224,893	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	33,036,446	0.000000	0.000000	6,719	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	14,458,276	0.000000	0.000000	2,319	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	15,637,878	0.000000	0.000000	0	55.00
56.00	05600 RADIOISOTOPE	0	11,699,610	0.000000	0.000000	2,127	56.00
57.00	05700 CT SCAN	0	94,456,433	0.000000	0.000000	60,200	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	24,887,595	0.000000	0.000000	4,794	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	65,447,409	0.000000	0.000000	68,203	59.00
60.00	06000 LABORATORY	0	122,907,801	0.000000	0.000000	138,560	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,454,409	0.000000	0.000000	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	37,427,751	0.000000	0.000000	9,247	65.00
66.00	06600 PHYSICAL THERAPY	0	7,094,482	0.000000	0.000000	8,108	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	5,313,169	0.000000	0.000000	5,210	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,867,683	0.000000	0.000000	1,570	68.00
69.00	06900 ELECTROCARDIOLOGY	0	17,555,773	0.000000	0.000000	10,352	69.00
69.01	06901 CARDIAC REHAB	0	596,633	0.000000	0.000000	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	28,551,810	0.000000	0.000000	834	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,583,611	0.000000	0.000000	15,806	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	30,397,573	0.000000	0.000000	794	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	122,821,796	0.000000	0.000000	173,598	73.00
74.00	07400 RENAL DIALYSIS	0	6,915,420	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	20,497,887	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	516,680	63,412,996	0.008148	0.008148	76,964	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	24,277,536	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	516,680	968,882,117			595,979	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	627	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	627	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 10/17/2017 3:54 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	438,493	134,228,783	0.003267	90,695	296	50.00
50.01	05001	ENDOSCOPY	15,733	18,482,384	0.000851	60,317	51	50.01
51.00	05100	RECOVERY ROOM	103,174	9,646,080	0.010696	10,148	109	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,125	5,224,893	0.011507	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,684	33,036,446	0.010494	131,462	1,380	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	40,223	14,458,276	0.002782	44,755	125	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	89,506	15,637,878	0.005724	12,828	73	55.00
56.00	05600	RADIOISOTOPE	63,135	11,699,610	0.005396	33,518	181	56.00
57.00	05700	CT SCAN	81,791	94,456,433	0.000866	214,357	186	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,660	24,887,595	0.001352	140,046	189	58.00
59.00	05900	CARDIAC CATHETERIZATION	86,252	65,447,409	0.001318	100,582	133	59.00
60.00	06000	LABORATORY	215,956	122,907,801	0.001757	1,067,485	1,876	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,479	7,454,409	0.001137	40,687	46	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	67,698	37,427,751	0.001809	644,343	1,166	65.00
66.00	06600	PHYSICAL THERAPY	82,414	7,094,482	0.011617	2,723,822	31,643	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,064	5,313,169	0.012999	2,512,649	32,662	67.00
68.00	06800	SPEECH PATHOLOGY	12,946	1,867,683	0.006932	258,160	1,790	68.00
69.00	06900	ELECTROCARDIOLOGY	7,950	17,555,773	0.000453	31,685	14	69.00
69.01	06901	CARDIAC REHAB	2,234	596,633	0.003744	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	19,010	28,551,810	0.000666	19,090	13	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,731	44,583,611	0.003134	210,742	660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,089	30,397,573	0.005201	10,561	55	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,437	122,821,796	0.001306	4,108,943	5,366	73.00
74.00	07400	RENAL DIALYSIS	36,544	6,915,420	0.005284	436,428	2,306	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	482,096	20,497,887	0.023519	8,568	202	90.00
91.00	09100	EMERGENCY	242,509	63,412,996	0.003824	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	24,277,536	0.000000	0	0	92.00
200.00		Total (lines 50-199)	3,063,933	968,882,117		12,911,871	80,522	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	516,680	0	516,680
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	516,680	0	516,680

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	134,228,783	0.000000	0.000000	90,695	50.00
50.01	05001 ENDOSCOPY	0	18,482,384	0.000000	0.000000	60,317	50.01
51.00	05100 RECOVERY ROOM	0	9,646,080	0.000000	0.000000	10,148	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,224,893	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	33,036,446	0.000000	0.000000	131,462	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	14,458,276	0.000000	0.000000	44,755	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	15,637,878	0.000000	0.000000	12,828	55.00
56.00	05600 RADIOISOTOPE	0	11,699,610	0.000000	0.000000	33,518	56.00
57.00	05700 CT SCAN	0	94,456,433	0.000000	0.000000	214,357	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	24,887,595	0.000000	0.000000	140,046	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	65,447,409	0.000000	0.000000	100,582	59.00
60.00	06000 LABORATORY	0	122,907,801	0.000000	0.000000	1,067,485	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,454,409	0.000000	0.000000	40,687	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	37,427,751	0.000000	0.000000	644,343	65.00
66.00	06600 PHYSICAL THERAPY	0	7,094,482	0.000000	0.000000	2,723,822	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	5,313,169	0.000000	0.000000	2,512,649	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,867,683	0.000000	0.000000	258,160	68.00
69.00	06900 ELECTROCARDIOLOGY	0	17,555,773	0.000000	0.000000	31,685	69.00
69.01	06901 CARDIAC REHAB	0	596,633	0.000000	0.000000	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	28,551,810	0.000000	0.000000	19,090	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,583,611	0.000000	0.000000	210,742	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	30,397,573	0.000000	0.000000	10,561	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	122,821,796	0.000000	0.000000	4,108,943	73.00
74.00	07400 RENAL DIALYSIS	0	6,915,420	0.000000	0.000000	436,428	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	20,497,887	0.000000	0.000000	8,568	90.00
91.00	09100 EMERGENCY	516,680	63,412,996	0.008148	0.008148	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	24,277,536	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	516,680	968,882,117			12,911,871	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,919	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	655	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	1,906	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	202	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	726	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	5,408	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.107154	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0.228558	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.250169	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	1,919	0	0	459	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	655	0	0	123	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.198866	0	0	0	0	56.00
57.00	05700	CT SCAN	0.041578	1,906	0	0	79	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	0	0	0	0	59.00
60.00	06000	LABORATORY	0.122822	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	202	0	0	16	69.00
69.01	06901	CARDIAC REHAB	1.570833	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	726	0	0	262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.343943	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.416972	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.238932	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	0	0	0	92.00
200.00		Subtotal (see instructions)		5,408	0	0	939	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		5,408	0	0	939	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 10/17/2017 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
50.01 05001 ENDOSCOPY	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		97,645	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		97,645	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)		80,347	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)		35,763	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)		69,028,502	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)		69,028,502	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)		69,028,502	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)		706.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		25,281,938	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)		25,281,938	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	12,232,075	8,379	1,459.85	4,163	6,077,356	43.00
43.01	NEONATAL ICU	3,659,739	3,028	1,208.63	0	0	43.01
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)					37,333,852	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					68,693,146	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)					909,049	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					640,724	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,549,773	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					67,143,373	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)					17,298	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					706.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					12,228,475	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,243,677	69,028,502	0.032504	12,228,475	397,474	90.00
91.00	Nursing School cost	0	69,028,502	0.000000	12,228,475	0	91.00
92.00	Allied health cost	0	69,028,502	0.000000	12,228,475	0	92.00
93.00	All other Medical Education	0	69,028,502	0.000000	12,228,475	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,506 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,506 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,506 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)			546 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,226,047 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,226,047 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,226,047 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)			814.11 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			444,504 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)			444,504 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
					Component CCN: 15-S002		Date/Time Prepared: 10/17/2017 3:54 pm
					Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
43.01 NEONATAL ICU	0	0	0.00	0	0	43.01	
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)					94,394	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					538,898	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)					10,161	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,907	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					12,068	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					526,830	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	28,028	1,226,047	0.022860	0	0	90.00
91.00	Nursing School cost	0	1,226,047	0.000000	0	0	91.00
92.00	Allied health cost	0	1,226,047	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,226,047	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,538	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,538	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)		10,538	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,566	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,845,932	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,845,932	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,845,932	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)		649.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,915,176	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)		4,915,176	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
					Component CCN: 15-T002		Date/Time Prepared: 10/17/2017 3:54 pm
					Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,395,818		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,310,994		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)					160,702		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					80,522		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					241,224		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,069,770		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	223,809	6,845,932	0.032692	0	0	90.00
91.00	Nursing School cost	0	6,845,932	0.000000	0	0	91.00
92.00	Allied health cost	0	6,845,932	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,845,932	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		97,645	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		97,645	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)		80,347	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)		8,491	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)		2,874	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)		69,028,502	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)		69,028,502	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)		69,028,502	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)		706.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,002,543	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)		6,002,543	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,077,863	2,874	722.99	0	0 42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	12,232,075	8,379	1,459.85	0	0 43.00	
43.01	NEONATAL ICU	3,659,739	3,028	1,208.63	0	0 43.01	
44.00	CORONARY CARE UNIT					44.00	
45.00	BURN INTENSIVE CARE UNIT					45.00	
46.00	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,771,052 48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,773,595 49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0 54.00	
55.00	Target amount per discharge					0.00 55.00	
56.00	Target amount (line 54 x line 55)					0 56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00	
58.00	Bonus payment (see instructions)					0 58.00	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00	
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00	
62.00	Relief payment (see instructions)					0 62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00	
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00	
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00	
77.00	Program capital-related costs (line 9 x line 76)					77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00	
81.00	Inpatient routine service cost per diem limitation					81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00	
83.00	Reasonable inpatient routine service costs (see instructions)					83.00	
84.00	Program inpatient ancillary services (see instructions)					84.00	
85.00	Utilization review - physician compensation (see instructions)					85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					17,298 87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					706.93 88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					12,228,475 89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,243,677	69,028,502	0.032504	12,228,475	397,474	90.00
91.00	Nursing School cost	0	69,028,502	0.000000	12,228,475	0	91.00
92.00	Allied health cost	0	69,028,502	0.000000	12,228,475	0	92.00
93.00	All other Medical Education	0	69,028,502	0.000000	12,228,475	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,506 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,506 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,506 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)			184 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)			2,874 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,226,047 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,226,047 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,226,047 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)			814.11 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			149,796 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			149,796 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
					Component CCN: 15-S002		Date/Time Prepared: 10/17/2017 3:54 pm
					Title XIX	Subprovider - IPF	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)						50,156	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						199,952	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	28,028	1,226,047	0.022860	0	0	90.00
91.00	Nursing School cost	0	1,226,047	0.000000	0	0	91.00
92.00	Allied health cost	0	1,226,047	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,226,047	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			10,538 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			10,538 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)			10,538 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)			259 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)			2,874 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,845,932 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,845,932 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			6,845,932 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)			649.64 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			168,257 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)			168,257 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
					Component CCN: 15-T002		Date/Time Prepared: 10/17/2017 3:54 pm
					Title XIX	Subprovider - IRF	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)						208,839	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						377,096	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	223,809	6,845,932	0.032692	0	0	90.00
91.00	Nursing School cost	0	6,845,932	0.000000	0	0	91.00
92.00	Allied health cost	0	6,845,932	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,845,932	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 10/17/2017 3:54 pm	
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		33,349,399	30.00
31.00	03100	INTENSIVE CARE UNIT		7,553,229	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107154	35,706,610	50.00
50.01	05001	ENDOSCOPY	0.228558	2,434,800	50.01
51.00	05100	RECOVERY ROOM	0.250169	1,687,787	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	42,766	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	4,640,336	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	2,216,611	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	417,795	55.00
56.00	05600	RADIOISOTOPE	0.198866	2,650,861	56.00
57.00	05700	CT SCAN	0.041578	15,623,694	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	4,215,528	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	14,857,865	59.00
60.00	06000	LABORATORY	0.122822	25,950,994	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	2,112,164	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	16,049,207	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	1,723,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	890,959	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	714,579	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	4,544,354	69.00
69.01	06901	CARDIAC REHAB	1.570833	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	1,859,054	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	9,438,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	8,340,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	45,506,121	73.00
74.00	07400	RENAL DIALYSIS	0.343943	3,877,028	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416972	178,857	90.00
91.00	09100	EMERGENCY	0.238932	9,949,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		215,630,316	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)		215,630,316	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		715,107	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107154	5,100	50.00
50.01	05001	ENDOSCOPY	0.228558	4,586	50.01
51.00	05100	RECOVERY ROOM	0.250169	888	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	6,719	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	2,319	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	0	55.00
56.00	05600	RADIOISOTOPE	0.198866	2,127	56.00
57.00	05700	CT SCAN	0.041578	60,200	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	4,794	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	68,203	59.00
60.00	06000	LABORATORY	0.122822	138,560	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	9,247	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	8,108	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	5,210	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	1,570	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	10,352	69.00
69.01	06901	CARDIAC REHAB	1.570833	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	834	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	15,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	173,598	73.00
74.00	07400	RENAL DIALYSIS	0.343943	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416972	0	90.00
91.00	09100	EMERGENCY	0.238932	76,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		595,979	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)		595,979	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		16,997	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		976	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		5,563,945	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107154	90,695	50.00
50.01	05001	ENDOSCOPY	0.228558	60,317	50.01
51.00	05100	RECOVERY ROOM	0.250169	10,148	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	131,462	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	44,755	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	12,828	55.00
56.00	05600	RADIOISOTOPE	0.198866	33,518	56.00
57.00	05700	CT SCAN	0.041578	214,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	140,046	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	100,582	59.00
60.00	06000	LABORATORY	0.122822	1,067,485	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	40,687	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	644,343	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	2,723,822	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	2,512,649	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	258,160	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	31,685	69.00
69.01	06901	CARDIAC REHAB	1.570833	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	19,090	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	210,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	10,561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	4,108,943	73.00
74.00	07400	RENAL DIALYSIS	0.343943	436,428	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416972	8,568	90.00
91.00	09100	EMERGENCY	0.238932	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,911,871	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		12,911,871	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 10/17/2017 3:54 pm	
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		5,382,622	30.00
31.00	03100	INTENSIVE CARE UNIT		947,152	31.00
31.01	03101	NEONATAL ICU		1,661,183	31.01
40.00	04000	SUBPROVIDER - I PF		138	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		531,835	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107154	7,723,932	50.00
50.01	05001	ENDOSCOPY	0.228558	360,819	50.01
51.00	05100	RECOVERY ROOM	0.250169	497,102	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	1,057,764	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	571,806	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	438,806	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	88,736	55.00
56.00	05600	RADIOISOTOPE	0.198866	402,882	56.00
57.00	05700	CT SCAN	0.041578	2,567,723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	609,988	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	2,003,502	59.00
60.00	06000	LABORATORY	0.122822	4,899,963	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	87,078	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	2,383,470	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	263,362	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	177,167	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	77,946	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	635,607	69.00
69.01	06901	CARDIAC REHAB	1.570833	9,661	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	680,886	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	7,375,081	73.00
74.00	07400	RENAL DIALYSIS	0.343943	285,669	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416972	19,700	90.00
91.00	09100	EMERGENCY	0.238932	1,830,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,049,523	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)		35,049,523	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		431,657	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107154	0	50.00
50.01	05001	ENDOSCOPY	0.228558	0	50.01
51.00	05100	RECOVERY ROOM	0.250169	158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.912569	9,310	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239237	7,575	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.187812	1,967	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.155462	0	55.00
56.00	05600	RADIOISOTOPE	0.198866	0	56.00
57.00	05700	CT SCAN	0.041578	5,725	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047844	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.098025	0	59.00
60.00	06000	LABORATORY	0.122822	86,771	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133348	4,971	65.00
66.00	06600	PHYSICAL THERAPY	0.371864	2,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388690	1,279	67.00
68.00	06800	SPEECH PATHOLOGY	0.372475	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079339	2,432	69.00
69.01	06901	CARDIAC REHAB	1.570833	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.066655	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	3,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.602377	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180670	77,052	73.00
74.00	07400	RENAL DIALYSIS	0.343943	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416972	0	90.00
91.00	09100	EMERGENCY	0.238932	46,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		249,587	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)		249,587	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
31.01	03101 NEONATAL ICU		0	31.01
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		365,655	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.107154	8,498	911 50.00
50.01	05001 ENDOSCOPY	0.228558	1,682	384 50.01
51.00	05100 RECOVERY ROOM	0.250169	1,805	452 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.912569	3,732	3,406 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.239237	12,733	3,046 54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.187812	2,745	516 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.155462	0	0 55.00
56.00	05600 RADIOISOTOPE	0.198866	2,749	547 56.00
57.00	05700 CT SCAN	0.041578	12,456	518 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047844	13,454	644 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.098025	0	0 59.00
60.00	06000 LABORATORY	0.122822	84,119	10,332 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.263866	987	260 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.133348	30,773	4,104 65.00
66.00	06600 PHYSICAL THERAPY	0.371864	180,232	67,022 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.388690	160,153	62,250 67.00
68.00	06800 SPEECH PATHOLOGY	0.372475	19,564	7,287 68.00
69.00	06900 ELECTROCARDIOLOGY	0.079339	1,055	84 69.00
69.01	06901 CARDIAC REHAB	1.570833	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.066655	905	60 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.361271	12,245	4,424 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.602377	820	494 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180670	192,335	34,749 73.00
74.00	07400 RENAL DIALYSIS	0.343943	21,368	7,349 74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.416972	0	0 90.00
91.00	09100 EMERGENCY	0.238932	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.503695	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		764,410	208,839 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		764,410	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		52,784,958	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)		2,636,874	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		3,982,451	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		390.61	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)		8.53	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		8.53	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.00	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)		3.00	12.00
13.00	Total allowable FTE count for the prior year.		3.00	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.		3.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		3.00	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		3.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.007680	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.007565	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.007565	21.00
22.00	IME payment adjustment (see instructions)		217,844	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		16,436	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-5.53	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)		217,844	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		16,436	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		9.83	30.00
31.00	Percentage of Medicaid patient days (see instructions)		30.44	31.00
32.00	Sum of lines 30 and 31		40.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)		22.44	33.00
34.00	Disproportionate share adjustment (see instructions)		2,961,236	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000864995	0.000869767	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	6,615,171	5,571,856	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,947,784	1,400,575	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	6,348,359		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	64,949,271		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)		64,965,707	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,613,101	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).		75,486	52.00
53.00	Nursing and Allied Health Managed Care payment		25,454	53.00
54.00	Special add-on payments for new technologies		22,196	54.00
54.01	Islet isolation add-on payment			54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		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)		81,068	58.00
59.00	Total (sum of amounts on lines 49 through 58)		69,783,012	59.00
60.00	Primary payer payments		38,816	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		69,744,196	61.00
62.00	Deductibles billed to program beneficiaries		5,032,188	62.00
63.00	Coinurance billed to program beneficiaries		1,036,877	63.00
64.00	Allowable bad debts (see instructions)		1,391,750	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		904,638	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		551,146	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		64,579,769	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		123,479	70.93
70.94	HRR adjustment amount (see instructions)		-1,061,564	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			686,629	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			62,955,055	71.00
71.01	Sequestration adjustment (see instructions)			1,259,101	71.01
72.00	Interim payments			60,433,138	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			1,262,816	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			20,036,176	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	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	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
10/17/2017 3:54 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	52,784,958	0	0	52,784,958	52,784,958	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	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	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,636,874	0	0	2,636,874	2,636,874	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	3,982,451	0	0	3,982,451	3,982,451	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007565	0.007565	0.007565	0.007565	0.007565	5.00
6.00	IME payment adjustment (see instructions)	22.00	217,844	0	0	217,844	217,844	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	16,436	0	16,436	0	16,436	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	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	217,844	0	0	217,844	217,844	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	16,436	0	16,436	0	16,436	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2244	0.2244	0.2244	0.2244	0.2244	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,961,236	0	0	2,961,236	2,961,236	11.00
11.01	Uncompensated care payments	36.00	6,348,359	0	6,183,970	1,662,829	7,846,799	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	64,949,271	0	6,183,970	58,765,301	64,949,271	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	64,965,707	0	6,200,406	58,765,301	64,965,707	15.00
16.00	Payment for inpatient program capital	50.00	4,613,101	0	0	4,613,101	4,613,101	16.00
17.00	Special add-on payments for new technologies	54.00	22,196	0	0	22,196	22,196	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	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
10/17/2017 3:54 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	6,200,406	63,400,598	69,601,004	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	4,224,033	0	0	4,224,033	4,224,033	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	16,086	0	0	16,086	16,086	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	0.0034	0.0034	0.0034	0.0034		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	14,362	0	0	14,362	14,362	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0849	0.0849	0.0849	0.0849		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	358,620	0	0	358,620	358,620	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,613,101	0	0	4,613,101	4,613,101	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002		Period: From 01/01/2015 To 12/31/2015		Worksheet E Part A Exhibit 5 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 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	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	52,784,958		52,784,958	52,784,958	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	2,636,874	0	2,636,874	2,636,874	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	3,982,451	0	3,982,451	3,982,451	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007565	0.007565	0.007565		5.00
6.00	IME payment adjustment (see instructions)	22.00	217,844	0	217,844	217,844	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	16,436	0	16,436	16,436	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	217,844	0	217,844	217,844	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	16,436	0	16,436	16,436	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2244	0.2244	0.2244		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,961,236	0	2,961,236	2,961,236	11.00
11.01	Uncompensated care payments	36.00	6,348,359	4,947,784	1,400,575	6,348,359	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	64,949,271	4,947,784	60,001,487	64,949,271	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	64,965,707	4,947,784	60,017,923	64,965,707	15.00
16.00	Payment for inpatient program capital	50.00	4,613,101	0	4,613,101	4,613,101	16.00
17.00	Special add-on payments for new technologies	54.00	22,196	0	22,196	22,196	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,947,784	64,653,220	69,601,004	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
10/17/2017 3:54 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	4,224,033	0	4,224,033	4,224,033	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	16,086	0	16,086	16,086	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	0.0034	0.0034	0.0034		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	14,362	0	14,362	14,362	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0849	0.0849	0.0849		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	358,620	0	358,620	358,620	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,613,101	0	4,613,101	4,613,101	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	123,479	0	123,479	123,479	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	-1,061,564	0	-1,061,564	-1,061,564	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		49,478	637,151	686,629	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,524	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,260,031	2.00
3.00	PPS payments		20,636,701	3.00
4.00	Outlier payment (see instructions)		212,937	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		73,293	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,524	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		41,612	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)		41,612	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 charge basis 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)		41,612	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		34,088	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		7,524	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		20,922,931	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)		4,061,164	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)		16,869,291	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		22,679	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)		16,891,970	30.00
31.00	Primary payer payments		54,997	31.00
32.00	Subtotal (line 30 minus line 31)		16,836,973	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)		1,451,047	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		943,181	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,008,721	36.00
37.00	Subtotal (see instructions)		17,780,154	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-23	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		17,780,177	40.00
40.01	Sequestration adjustment (see instructions)		355,604	40.01
41.00	Interim payments		17,116,749	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		307,824	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		939	2.00
3.00	PPS payments		469	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		469	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)		119	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)		350	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)		350	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		350	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		350	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		350	40.00
40.01	Sequestration adjustment (see instructions)		7	40.01
41.00	Interim payments		342	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1	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: 15-0002

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

Worksheet E-1
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		59,828,159		16,402,151	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	12/31/2015	604,979	12/31/2015	714,598	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)		604,979		714,598	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)		60,433,138		17,116,749	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		1,262,816		307,824	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		61,695,954		17,424,573	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0002
Component CCN: 15-S002

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

Worksheet E-1
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		433,869		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		433,869		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		6,076		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		439,945		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0002
Component CCN: 15-T002

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

Worksheet E-1
Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		9,384,097		342	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)		9,384,097		342	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		105,658		0	6.02
7.00	Total Medicare program liability (see instructions)		9,278,439		343	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: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 10/17/2017 3:54 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		16,026	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		39,926	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3,385	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		91,754	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		1,073,464,141	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		37,097,555	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			466,860 1.00
2.00	Net IPF PPS Outlier Payments			42,328 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			4.126027 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			509,188 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			509,188 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			509,188 18.00
19.00	Deductibles			63,000 19.00
20.00	Subtotal (line 18 minus line 19)			446,188 20.00
21.00	Coinsurance			3,465 21.00
22.00	Subtotal (line 20 minus line 21)			442,723 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			8,574 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			5,573 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			448,296 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			627 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			448,923 31.00
31.01	Sequestration adjustment (see instructions)			8,978 31.01
32.00	Interim payments			433,869 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			6,076 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			42,328 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8,949,642 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0561 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			393,784 3.00
4.00	Outlier Payments			226,689 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			28.871233 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			9,570,115 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			9,570,115 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			9,570,115 19.00
20.00	Deductibles			33,888 20.00
21.00	Subtotal (line 19 minus line 20)			9,536,227 21.00
22.00	Coinsurance			99,679 22.00
23.00	Subtotal (line 21 minus line 22)			9,436,548 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			48,073 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			31,247 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			15,120 26.00
27.00	Subtotal (sum of lines 23 and 25)			9,467,795 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			9,467,795 32.00
32.01	Sequestration adjustment (see instructions)			189,356 32.01
33.00	Interim payments			9,384,097 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			-105,658 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			96,468 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			226,689 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		11,773,595		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		11,773,595	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		11,773,595	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		8,522,930		8.00
9.00	Ancillary service charges		35,049,523	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		43,572,453	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		43,572,453	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		31,798,858	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		11,773,595	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		11,773,595	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		11,773,595	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		11,773,595	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		11,773,595	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		11,773,595	0	40.00
41.00	Interim payments		13,593,705	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-1,820,110	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 10/17/2017 3:54 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	199,952		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	199,952	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	199,952	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	431,657		8.00
9.00	Ancillary service charges	249,587	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	681,244	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	681,244	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	481,292	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	199,952	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	199,952	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	199,952	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	199,952	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	199,952	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	199,952	0	40.00
41.00	Interim payments	453,272	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-253,320	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 10/17/2017 3:54 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	377,096		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	377,096	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	377,096	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	365,655		8.00
9.00	Ancillary service charges	764,410	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,130,065	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,130,065	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	752,969	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	377,096	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	377,096	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	377,096	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	377,096	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	377,096	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	377,096	0	40.00
41.00	Interim payments	561,402	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-184,306	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 10/17/2017 3:54 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			10.83	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			10.83	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.00	6.00
7.00	Enter the lesser of line 5 or line 6			3.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.42	2.42	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.42	2.42	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.42		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.50		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.54		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.49		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	2.49		17.00
18.00	Per resident amount	80,404.81	80,404.81		18.00
19.00	Approved amount for resident costs	0	200,208	200,208	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			200,208	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	48,038	3,385		26.00
27.00	Total Inpatient Days (see instructions)	103,902	103,902		27.00
28.00	Ratio of inpatient days to total inpatient days	0.462340	0.032579		28.00
29.00	Program direct GME amount	92,564	6,523		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		922		30.00
31.00	Net Program direct GME amount			98,165	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet E-4 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		6,915,420	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		77,543,038	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		38,816	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		77,504,222	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		23,341,787	42.00
43.00	Primary payer payments (see instructions)		56,174	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		23,285,613	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		100,789,835	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.768969	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.231031	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		98,165	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		75,486	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		22,679	50.00

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

Provider CCN: 15-0002

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

Worksheet G

Date/Time Prepared:
10/17/2017 3:54 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	19,279,010	0	0	0	1.00
2.00	Temporary investments	7,916,844	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,825,667	0	0	0	4.00
5.00	Other receivable	9,078,768	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	14,678,285	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)	94,778,574	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,745,499	0	0	0	12.00
13.00	Land improvements	6,370,152	0	0	0	13.00
14.00	Accumulated depreciation	-318,813,935	0	0	0	14.00
15.00	Buildings	248,481,929	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	8,493,123	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	150,734,901	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	25,742,129	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)	124,753,798	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	141,024,711	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	5,777,324	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	146,802,035	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	366,334,407	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,201,781	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,256,749	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	19,804,823	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,263,353	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	68,251,438	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	32,009,576	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	100,261,014	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	134,524,367	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	231,810,040	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	231,810,040	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	366,334,407	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0002

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

Worksheet G-1

Date/Time Prepared:
10/17/2017 3:54 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		230,103,670		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,661,368			2.00
3.00	Total (sum of line 1 and line 2)		231,765,038		0	3.00
4.00	INCREASE IN TEMPORARILY RESTRICTED N	45,002		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		45,002		0	10.00
11.00	Subtotal (line 3 plus line 10)		231,810,040		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		231,810,040		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	INCREASE IN TEMPORARILY RESTRICTED N		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0002

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
10/17/2017 3:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	70,721,541		70,721,541	1.00
2.00	SUBPROVIDER - IPF	1,984,549		1,984,549	2.00
3.00	SUBPROVIDER - IRF	7,786,843		7,786,843	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)	80,492,933		80,492,933	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,276,741		15,276,741	11.00
11.01	NEONATAL ICU	5,478,673		5,478,673	11.01
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)	20,755,414		20,755,414	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	101,248,347		101,248,347	17.00
18.00	Ancillary services	483,630,743	377,062,952	860,693,695	18.00
19.00	Outpatient services	24,187,670	84,000,749	108,188,419	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		3,333,677	3,333,677	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	PHYSICIAN	0	44,052,934	44,052,934	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	609,066,760	508,450,312	1,117,517,072	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		320,811,026		29.00
30.00	MEDI CAID ASSESSMENT FEE	11,145,387			30.00
31.00	FOUNDATION	220,847			31.00
32.00	AUDIT ADJUSTMENT	62,901			32.00
33.00	ROUNDING	89,821			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		11,518,956		36.00
37.00	AUDIT ADJUSTMENT	2,328,555			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		2,328,555		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		330,001,427		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0002

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

Worksheet G-3

Date/Time Prepared:
10/17/2017 3:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,117,517,072	1.00
2.00	Less contractual allowances and discounts on patients' accounts	837,526,042	2.00
3.00	Net patient revenues (line 1 minus line 2)	279,991,030	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	330,001,427	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-50,010,397	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-1,459,365	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	4,538,803	24.00
24.01	MEDICAID DSH REVENUE	50,873,132	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	98,841	24.02
24.03	NONOPERATING INCOME	35,000	24.03
25.00	Total other income (sum of lines 6-24)	54,086,411	25.00
26.00	Total (line 5 plus line 25)	4,076,014	26.00
27.00	PENSION-RELATED CHANGES	2,414,646	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,414,646	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,661,368	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0002

Period: From 01/01/2015

Worksheet H

HHA CCN: 15-7536

To 12/31/2015

Date/Time Prepared: 10/17/2017 3:54 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	382,223	0	0	0	382,223	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	786,395	0	0	341,889	1,128,284	6.00
7.00	Physical Therapy	441,293	0	0	0	441,293	7.00
8.00	Occupational Therapy	103,535	0	0	0	103,535	8.00
9.00	Speech Pathology	43,400	0	0	0	43,400	9.00
10.00	Medical Social Services	1,446	0	0	0	1,446	10.00
11.00	Home Health Aide	78,551	0	0	0	78,551	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,836,843	0	0	341,889	2,178,732	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-10,883	371,340	0	371,340		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,128,284	0	1,128,284		6.00
7.00	Physical Therapy	0	441,293	0	441,293		7.00
8.00	Occupational Therapy	0	103,535	0	103,535		8.00
9.00	Speech Pathology	0	43,400	0	43,400		9.00
10.00	Medical Social Services	0	1,446	0	1,446		10.00
11.00	Home Health Aide	0	78,551	0	78,551		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-10,883	2,167,849	0	2,167,849		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Prepared: 10/17/2017 3:54 pm
		HHA CCN: 15-7536	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	371,340	0	0	0	371,340	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,128,284	0	0	0	1,128,284	6.00
7.00	Physical Therapy	441,293	0	0	0	441,293	7.00
8.00	Occupational Therapy	103,535	0	0	0	103,535	8.00
9.00	Speech Pathology	43,400	0	0	0	43,400	9.00
10.00	Medical Social Services	1,446	0	0	0	1,446	10.00
11.00	Home Health Aide	78,551	0	0	0	78,551	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,167,849	0	0	0	2,167,849	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	371,340					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	233,216	1,361,500				6.00
7.00	Physical Therapy	91,216	532,509				7.00
8.00	Occupational Therapy	21,401	124,936				8.00
9.00	Speech Pathology	8,971	52,371				9.00
10.00	Medical Social Services	299	1,745				10.00
11.00	Home Health Aide	16,237	94,788				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		2,167,849				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Prepared: 10/17/2017 3:54 pm
			Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-371,340	1,796,509
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,128,284
7.00	Physical Therapy	0	0	0	0	0	441,293
8.00	Occupational Therapy	0	0	0	0	0	103,535
9.00	Speech Pathology	0	0	0	0	0	43,400
10.00	Medical Social Services	0	0	0	0	0	1,446
11.00	Home Health Aide	0	0	0	0	0	78,551
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-371,340	1,796,509
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		371,340
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.206701

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

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

Worksheet H-2 Part I

HHA CCN: 15-7536

Date/Time Prepared: 10/17/2017 3:54 pm

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Cost Center Description	HHA Trial Balance (1)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT					
	0	1.00	4.00	5.01	5.02	5.03	
1.00 Administrative and General	0	0	330,806	0	7,715	9,096	1.00
2.00 Skilled Nursing Care	1,361,500	0	0	0	0	0	2.00
3.00 Physical Therapy	532,509	0	0	0	0	0	3.00
4.00 Occupational Therapy	124,936	0	0	0	0	0	4.00
5.00 Speech Pathology	52,371	0	0	0	0	0	5.00
6.00 Medical Social Services	1,745	0	0	0	0	0	6.00
7.00 Home Health Aide	94,788	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,167,849	0	330,806	0	7,715	9,096	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	5.04	5A.04	5.05	5.06	7.00	8.00	
1.00 Administrative and General	12,932	360,549	52,636	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,361,500	198,762	0	0	0	2.00
3.00 Physical Therapy	0	532,509	77,740	0	0	0	3.00
4.00 Occupational Therapy	0	124,936	18,239	0	0	0	4.00
5.00 Speech Pathology	0	52,371	7,646	0	0	0	5.00
6.00 Medical Social Services	0	1,745	255	0	0	0	6.00
7.00 Home Health Aide	0	94,788	13,838	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	12,932	2,528,398	369,116	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2015

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2015

Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1,175	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,175	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
		16.00	17.00	17.01	17.02	21.00	22.00		
1.00	Administrative and General	13,385	0	3,231	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	13,385	0	3,231	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2015

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2015

Part I
Date/Time Prepared:
10/17/2017 3:54 pm

Home Health Agency I

PPS

Cost Center Description	PARAMED ED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	23.00	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	430,976	0	430,976			1.00
2.00 Skilled Nursing Care	0	1,560,262	0	1,560,262	270,670	1,830,932	2.00
3.00 Physical Therapy	0	610,249	0	610,249	105,865	716,114	3.00
4.00 Occupational Therapy	0	143,175	0	143,175	24,838	168,013	4.00
5.00 Speech Pathology	0	60,017	0	60,017	10,412	70,429	5.00
6.00 Medical Social Services	0	2,000	0	2,000	347	2,347	6.00
7.00 Home Health Aide	0	108,626	0	108,626	18,844	127,470	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	2,915,305	0	2,915,305	430,976	2,915,305	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.173478		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0002
HHA CCN: 15-7536

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

Worksheet H-2
Part II
Date/Time Prepared:
10/17/2017 3:54 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0	1,832,997	0	0	87,934	3,382,710	3,382,710	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	1,832,997	0	0	87,934	3,382,710	3,382,710	20.00
21.00 Total cost to be allocated	0	330,806	0	0	7,715	9,096	12,932	21.00
22.00 Unit cost multiplier	0.000000	0.180473	0.000000	0.000000	0.087736	0.002689	0.003823	22.00
Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)		
	5A.05	5.05	5.06	7.00	8.00	9.00		
1.00 Administrative and General	0	360,549	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	1,361,500	0	0	0	0	2.00	
3.00 Physical Therapy	0	532,509	0	0	0	0	3.00	
4.00 Occupational Therapy	0	124,936	0	0	0	0	4.00	
5.00 Speech Pathology	0	52,371	0	0	0	0	5.00	
6.00 Medical Social Services	0	1,745	0	0	0	0	6.00	
7.00 Home Health Aide	0	94,788	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19)	0	2,528,398	0	0	0	0	20.00	
21.00 Total cost to be allocated	0	369,116	0	0	0	0	21.00	
22.00 Unit cost multiplier		0.145988	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2015 To 12/31/2015	Worksheet H-2 Part II Date/Time Prepared: 10/17/2017 3:54 pm
			Home Health Agency I	PPS

Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	24,627	3,333,677	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	24,627	3,333,677	20.00
21.00	Total cost to be allocated	0	0	0	1,175	13,385	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.047712	0.004015	22.00

Cost Center Description	INTERNS & RESIDENTS						
	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALARIES & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED PROGRAM (ASSIGNED TIME)	
	17.00	17.01	17.02	21.00	22.00	23.00	
1.00	Administrative and General	0	997	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	997	0	0	0	20.00
21.00	Total cost to be allocated	0	3,231	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	3.240722	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Prepared: 10/17/2017 3:54 pm
		HHA CCN: 15-7536	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,830,932		1,830,932	10,783	169.80	1.00
2.00	Physical Therapy	3.00	716,114	0	716,114	5,661	126.50	2.00
3.00	Occupational Therapy	4.00	168,013	0	168,013	1,213	138.51	3.00
4.00	Speech Pathology	5.00	70,429	0	70,429	293	240.37	4.00
5.00	Medical Social Services	6.00	2,347		2,347	12	195.58	5.00
6.00	Home Health Aide	7.00	127,470		127,470	1,949	65.40	6.00
7.00	Total (sum of lines 1-6)		2,915,305	0	2,915,305	19,911		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 + col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	4,503		8.00
9.00	Physical Therapy		23844	0	3,096		9.00
10.00	Occupational Therapy		23844	0	615		10.00
11.00	Speech Pathology		23844	0	125		11.00
12.00	Medical Social Services		23844	0	9		12.00
13.00	Home Health Aide		23844	0	1,284		13.00
14.00	Total (sum of lines 8-13)			0	9,632		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,503		0	764,609	1.00
2.00	Physical Therapy	0	3,096		0	391,644	2.00
3.00	Occupational Therapy	0	615		0	85,184	3.00
4.00	Speech Pathology	0	125		0	30,046	4.00
5.00	Medical Social Services	0	9		0	1,760	5.00
6.00	Home Health Aide	0	1,284		0	83,974	6.00
7.00	Total (sum of lines 1-6)	0	9,632		0	1,357,217	7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00
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Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2015 To 12/31/2015		Worksheet H-3 Part I Date/Time Prepared: 10/17/2017 3:54 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges				Cost of Services				
	Part A	Part B		Part A		Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00			
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description									
		Total Program Cost (sum of col.s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	764,609						1.00	
2.00	Physical Therapy	391,644						2.00	
3.00	Occupational Therapy	85,184						3.00	
4.00	Speech Pathology	30,046						4.00	
5.00	Medical Social Services	1,760						5.00	
6.00	Home Health Aide	83,974						6.00	
7.00	Total (sum of lines 1-6)	1,357,217						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part II Date/Time Prepared: 10/17/2017 3:54 pm
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.371864	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.388690	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.372475	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.361271	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.180670	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2015 To 12/31/2015	Worksheet H-4 Part I-11 Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	1,177	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-1,177
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	1,471,892
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	23,257
13.00	Total PPS Reimbursement - LUPA Episodes		0	24,653
14.00	Total PPS Reimbursement - PEP Episodes		0	43,447
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	5,535
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	2,112
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,569,719
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	1,569,719
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	1,569,719
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,569,719
30.00	OTHER PS&R ADJUSTMENTS		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	1,569,719
31.01	Sequestration adjustment (see instructions)		0	31,394
32.00	Interim payments (see instructions)		0	1,538,325
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0002
HHA CCN: 15-7536

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

Worksheet H-5
Date/Time Prepared:
10/17/2017 3:54 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,538,325	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,538,325	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,538,325	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0002	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 10/17/2017 3:54 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,224,033	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		16,086	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)		251.67	3.00
4.00	Number of interns & residents (see instructions)		3.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.34	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)		14,362	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		9.83	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		30.44	8.00
9.00	Sum of lines 7 and 8		40.27	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.49	10.00
11.00	Disproportionate share adjustment (see instructions)		358,620	11.00
12.00	Total prospective capital payments (see instructions)		4,613,101	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