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: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/28/2018 4:20 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/28/2018 Time: 4:20 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLUFFTON REGIONAL MEDICAL CENTER (15-0075) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	98,657	36,250	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	98,657	36,250	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 S. MAIN STREET	PO Box:			1.00
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	622	144	0	0	425	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:19 pm

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

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 4:19 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 4:19 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:19 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:19 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	203,659	59,270	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 4:19 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	09/01/2017	11/29/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2018 4:19 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/02/2018	Y	02/02/2018	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)	N		N		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: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2018 4:19 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2016	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.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 4:19 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 MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 4:19 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	55	20,075	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)		55	20,075	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		62	22,630	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	13	4,745		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		75				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2018 4:19 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,697	587	3,536			1.00
2.00	HMO and other (see instructions)	907	425				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,697	587	3,536			7.00
8.00	INTENSIVE CARE UNIT	312	48	748			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		131	461			13.00
14.00	Total (see instructions)	2,009	766	4,745	0.00	219.19	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,562	0	3,232	0.00	13.22	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	232.41	27.00
28.00	Observation Bed Days		0	861			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	203			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2018 4:19 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	552	306	1,652	1.00
2.00	HMO and other (see instructions)			217	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	552	306	1,652	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2018 4:19 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	12,815,062	0	12,815,062	483,423.00	26.51	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	665,092	0	665,092	27,488.00	24.20	9.00
10.00	Excluded area salaries (see instructions)		5,997	82,914	88,911	3,286.00	27.06	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		161,759	0	161,759	2,583.42	62.61	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		93,724	0	93,724	788.47	118.87	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,085,844	0	1,085,844	31,750.24	34.20	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,092,090	0	3,092,090			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		271,404	0	271,404			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	192,676	0	192,676	6,147.00	31.34	26.00
27.00	Administrative & General	5.00	1,710,178	-242,287	1,467,891	62,611.00	23.44	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2018 4:19 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	360,807	0	360,807	14,261.00	25.30	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	223,088	0	223,088	16,009.00	13.94	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	413,656	-240,608	173,048	12,849.62	13.47	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	240,608	240,608	17,866.38	13.47	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	820,316	159,373	979,689	24,396.00	40.16	38.00
39.00	Central Services and Supply	14.00	142,509	0	142,509	8,216.00	17.35	39.00
40.00	Pharmacy	15.00	516,933	0	516,933	13,407.00	38.56	40.00
41.00	Medical Records & Medical Records Library	16.00	280,816	0	280,816	14,630.00	19.19	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/28/2018 4:19 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		12,815,062	0	12,815,062	483,423.00	26.51	1.00
2.00	Excluded area salaries (see instructions)		671,089	82,914	754,003	30,774.00	24.50	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12,143,973	-82,914	12,061,059	452,649.00	26.65	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,341,327	0	1,341,327	35,122.13	38.19	4.00
5.00	Subtotal wage-related costs (see inst.)		3,092,090	0	3,092,090	0.00	25.64	5.00
6.00	Total (sum of lines 3 thru 5)		16,577,390	-82,914	16,494,476	487,771.13	33.82	6.00
7.00	Total overhead cost (see instructions)		4,660,979	-82,914	4,578,065	190,393.00	24.05	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/28/2018 4:19 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	263,728	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	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)	1,699,575	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	4,866	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,185	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-425	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	9,157	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	392,455	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	768,081	17.00
18.00	Medicare Taxes - Employers Portion Only	179,632	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	34,473	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,362,727	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V | Date/Time Prepared: 2/28/2018 4:19 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	161,759	3,362,727	1.00
2.00	Hospital	161,759	3,091,322	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	248,145	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	23,260	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/28/2018 4:19 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	27	0	27	12.00
13.00		RUB	146	0	146	13.00
14.00		RUA	22	0	22	14.00
15.00		RVC	138	0	138	15.00
16.00		RVB	288	0	288	16.00
17.00		RVA	53	0	53	17.00
18.00		RHC	124	0	124	18.00
19.00		RHB	413	0	413	19.00
20.00		RHA	54	0	54	20.00
21.00		RMC	2	0	2	21.00
22.00		RMB	112	0	112	22.00
23.00		RMA	57	0	57	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	7	0	7	29.00
30.00		HE1	5	0	5	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	32	0	32	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	9	0	9	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	10	0	10	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	9	0	9	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	48	0	48	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/28/2018 4:19 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	4	0	4	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	2	0	2	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,562	0	1,562	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,544,863			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/28/2018 4:19 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.146992	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,615,169	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	-1,853,747	5.00
6.00	Medicaid charges	30,656,952	6.00
7.00	Medicaid cost (line 1 times line 6)	4,506,327	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,744,905	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)	21,477	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	210,060	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	30,877	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)	9,400	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,754,305	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)	3,144,470	376	3,144,846	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	462,212	376	462,588	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	462,212	376	462,588	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,545,141	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	44,766	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	68,871	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	2,476,270	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	388,097	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	850,685	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,604,990	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,047,808	1,047,808	251,897	1,299,705	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,428,264	2,428,264	268,652	2,696,916	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	192,676	102,699	295,375	2,406,976	2,702,351	4.00
5.01	01160	COMMUNICATIONS	0	0	0	485,799	485,799	5.01
5.02	00540	ADMITTING	0	0	0	423,801	423,801	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	880,953	880,953	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,710,178	9,391,068	11,101,246	-4,864,468	6,236,778	5.04
7.00	00700	OPERATION OF PLANT	360,807	1,514,753	1,875,560	-2,991	1,872,569	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,407	117,407	0	117,407	8.00
9.00	00900	HOUSEKEEPING	223,088	142,957	366,045	-868	365,177	9.00
10.00	01000	DIETARY	413,656	337,729	751,385	-437,483	313,902	10.00
11.00	01100	CAFETERIA	0	0	0	436,454	436,454	11.00
13.00	01300	NURSING ADMINISTRATION	820,316	136,630	956,946	159,018	1,115,964	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,509	1,242,698	1,385,207	-825,426	559,781	14.00
15.00	01500	PHARMACY	516,933	1,297,716	1,814,649	-1,064,337	750,312	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	280,816	272,854	553,670	-4,305	549,365	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,905,750	1,301,897	3,207,647	-811,010	2,396,637	30.00
31.00	03100	INTENSIVE CARE UNIT	657,910	81,413	739,323	-1,078	738,245	31.00
43.00	04300	NURSERY	0	0	0	291,167	291,167	43.00
44.00	04400	SKILLED NURSING FACILITY	665,092	117,151	782,243	-4,091	778,152	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	997,055	1,108,705	2,105,760	-38,651	2,067,109	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	478,216	478,216	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	923,436	294,013	1,217,449	-85,809	1,131,640	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	58,966	77,964	136,930	0	136,930	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	719,162	921,968	1,641,130	-18,835	1,622,295	60.00
65.00	06500	RESPIRATORY THERAPY	328,876	41,646	370,522	-684	369,838	65.00
66.00	06600	PHYSICAL THERAPY	794,493	89,496	883,989	-3,093	880,896	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	170,885	13,250	184,135	0	184,135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	184,937	184,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	665,488	665,488	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,001,117	1,001,117	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	101,621	20,269	121,890	-718	121,172	76.01
76.03	03953	WOUND CARE	31,619	15,540	47,159	-876	46,283	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,705	12,556	59,261	0	59,261	90.00
91.00	09100	EMERGENCY	746,516	404,130	1,150,646	-1,853	1,148,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,809,065	22,532,581	35,341,646	-232,101	35,109,545	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,857	25,857	-24	25,833	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	232,125	232,125	194.01
194.02	07952	SENIOR CIRCLE	5,997	2,744	8,741	0	8,741	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,815,062	22,561,182	35,376,244	0	35,376,244	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 4:19 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	447,475	1,747,180		1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	0		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-215,486	2,481,430		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-779	2,701,572		4.00
5.01	01160	COMMUNICATIONS	-32,396	453,403		5.01
5.02	00540	ADMITTING	0	423,801		5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	880,953		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,331,505	4,905,273		5.04
7.00	00700	OPERATION OF PLANT	0	1,872,569		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,407		8.00
9.00	00900	HOUSEKEEPING	0	365,177		9.00
10.00	01000	DIETARY	0	313,902		10.00
11.00	01100	CAFETERIA	-33,917	402,537		11.00
13.00	01300	NURSING ADMINISTRATION	-18,864	1,097,100		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	559,781		14.00
15.00	01500	PHARMACY	0	750,312		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-401	548,964		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-800,120	1,596,517		30.00
31.00	03100	INTENSIVE CARE UNIT	0	738,245		31.00
43.00	04300	NURSERY	0	291,167		43.00
44.00	04400	SKILLED NURSING FACILITY	0	778,152		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-701,989	1,365,120		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	478,216		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-43,519	1,088,121		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	136,930		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,622,295		60.00
65.00	06500	RESPIRATORY THERAPY	0	369,838		65.00
66.00	06600	PHYSICAL THERAPY	0	880,896		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	184,135		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	184,937		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	665,488		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,001,117		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	121,172		76.01
76.03	03953	WOUND CARE	0	46,283		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	59,261		90.00
91.00	09100	EMERGENCY	-208,902	939,891		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,940,403	32,169,142		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,833		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0		194.00
194.01	07955	MARKETING	0	232,125		194.01
194.02	07952	SENIOR CIRCLE	0	8,741		194.02
194.03	07953	BUSINESS HEALTH	0	0		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,940,403	32,435,841		200.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 4:19 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,410,407		1.00
	TOTALS		0	2,410,407		
	B - RECLASS OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,273		1.00
	TOTALS		0	1,273		
	C - RECLASS RENTAL AND LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	262,191		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
	TOTALS		0	262,191		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46,964		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	204,933		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,461		3.00
	TOTALS		0	258,358		
	E - RECLASS MARKETING DEPT					
1.00	MARKETING	194.01	82,914	149,211		1.00
	TOTALS		82,914	149,211		
	F - RECLASS CNO COSTS					
1.00	NURSING ADMINISTRATION	13.00	159,373	0		1.00
	TOTALS		159,373	0		
	G - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	183,664		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	665,488		2.00
	TOTALS		0	849,152		
	H - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,001,117		1.00
	TOTALS		0	1,001,117		
	I - RECLASS LABOR AND DELIVERY COSTS					
1.00	NURSERY	43.00	204,090	87,077		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	335,200	143,016		2.00
	TOTALS		539,290	230,093		
	L - RECLASS A PORTION OF DIETARY TO CAFE					
1.00	CAFETERIA	11.00	240,608	195,846		1.00
	TOTALS		240,608	195,846		
	M - RECLASS ADMIN AND GENERAL COSTS					
1.00	COMMUNICATIONS	5.01	44,504	441,295		1.00
2.00	ADMITTING	5.02	364,205	59,596		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	103,258	777,695		3.00
	TOTALS		511,967	1,278,586		
500.00	Grand Total: Increases		1,534,152	6,636,234		500.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 4:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,410,407	0		1.00
	TOTALS		0	2,410,407			
	B - RECLASS OXYGEN						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,273	0		1.00
	TOTALS		0	1,273			
	C - RECLASS RENTAL AND LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,431	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	13,652	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,991	0		3.00
4.00	HOUSEKEEPING	9.00	0	868	0		4.00
5.00	DIETARY	10.00	0	1,029	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	355	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,725	0		7.00
8.00	PHARMACY	15.00	0	63,220	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,305	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	41,627	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	1,078	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	4,091	0		12.00
13.00	OPERATING ROOM	50.00	0	927	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	85,809	0		14.00
15.00	LABORATORY	60.00	0	18,835	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	684	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	3,093	0		17.00
18.00	SLEEP LAB	76.01	0	718	0		18.00
19.00	WOUND CARE	76.03	0	876	0		19.00
20.00	EMERGENCY	91.00	0	1,853	0		20.00
21.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	24	0		21.00
	TOTALS		0	262,191			
	D - RECLASS OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	258,358	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	258,358			
	E - RECLASS MARKETING DEPT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	82,914	149,211	0		1.00
	TOTALS		82,914	149,211			
	F - RECLASS CNO COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	159,373	0	0		1.00
	TOTALS		159,373	0			
	G - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	811,428	0		1.00
2.00	OPERATING ROOM	50.00	0	37,724	0		2.00
	TOTALS		0	849,152			
	H - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,001,117	0		1.00
	TOTALS		0	1,001,117			
	I - RECLASS LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	539,290	230,093	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		539,290	230,093			
	L - RECLASS A PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	240,608	195,846	0		1.00
	TOTALS		240,608	195,846			
	M - RECLASS ADMIN AND GENERAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	511,967	1,278,586	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		511,967	1,278,586			
500.00	Grand Total: Decreases		1,534,152	6,636,234			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I Date/Time Prepared: 2/28/2018 4:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,844,900	0	0	0	0	1.00
2.00	Land Improvements	748,002	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,420,896	1,849	0	1,849	1,170,000	3.00
4.00	Building Improvements	4,955,329	577,392	0	577,392	123,220	4.00
5.00	Fixed Equipment	3,980,233	0	0	0	7,434	5.00
6.00	Movable Equipment	16,650,054	2,267,059	0	2,267,059	200,464	6.00
7.00	HIT designated Assets	4,206,037	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,805,451	2,846,300	0	2,846,300	1,501,118	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	55,805,451	2,846,300	0	2,846,300	1,501,118	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,844,900	0	1.00
2.00	Land Improvements	748,002	0	2.00
3.00	Buildings and Fixtures	20,252,745	0	3.00
4.00	Building Improvements	5,409,501	0	4.00
5.00	Fixed Equipment	3,972,799	0	5.00
6.00	Movable Equipment	18,716,649	0	6.00
7.00	HIT designated Assets	4,206,037	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,150,633	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	57,150,633	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2018 4:19 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	1,047,808	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,428,264	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,476,072	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	1,047,808	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,428,264	2.00
3.00	Total (sum of lines 1-2)	0	3,476,072	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2018 4:19 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	38,433,983	0	38,433,983	0.672503	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	18,716,650	0	18,716,650	0.327497	0	2.00
3.00	Total (sum of lines 1-2)	57,150,633	0	57,150,633	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	1,334,819	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,115,250	262,191	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,450,069	262,191	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	136,211	46,964	204,933	24,253	1,747,180	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,461	0	97,528	2,481,430	2.00
3.00	Total (sum of lines 1-2)	136,211	53,425	204,933	121,781	4,228,610	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 4:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-32,396	COMMUNICATIONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-406	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,084,028			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-385,208			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-33,917	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-401	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	287,011	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - WELLS CRC COSTS-BLDG & FIXT		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-313,014	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 4:19 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION	B	-9,680	NURSING ADMINISTRATION	13.00	0	33.00
33.01	FITNESS REVENUE	B	-496,485	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	OTHER MISC REVENUE	B	-13,142	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	TRAINING REVENUE	A	-1,250	NURSING ADMINISTRATION	13.00	0	33.03
33.04	PATIENT PHONES BENEFITS	A	-779	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING	A	-36,346	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	LOBBYING EXPENSE	A	-3,081	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	PHYSICIAN RECRUITING	A	-3,025	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	CHARITABLE CONTRIBUTIONS	A	-34,525	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CRNA COSTS	A	-701,989	OPERATING ROOM	50.00	0	33.09
33.10	PENALTIES/LATE FEES	A	-16	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.12	MEMBERSHIPS/DUES	A	-43,734	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	LEGAL FEES	A	-33,992	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,940,403				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2018 4:19 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL-	136,211	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	8,221	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	2,301	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	121,061	0	4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	473,572	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	16,032	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	99,936	0	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	926,684	0	4.04
4.05	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	721,820	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	7,063	4.06
4.07	5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	23,151	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	540,645	4.08
4.09	5.04	OTHER ADMINISTRATIVE AND GEN	SSC ALLOCATION	0	450,558	4.09
4.10	5.04	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	0	221,927	4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	21,475	4.11
4.12	5.04	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	145,485	4.12
4.13	5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	21,545	4.13
4.14	5.04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	262,929	273,777	4.14
4.17	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	4,524	9,233	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,051,471	2,436,679	5.00

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

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

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

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

6.00	B	CHS, INC.	100.00	CHS, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2018 4:19 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	136,211	11		1.00
2.00	8,221	14		2.00
3.00	2,301	14		3.00
4.00	121,061	0		4.00
4.01	473,572	0		4.01
4.02	16,032	14		4.02
4.03	99,936	14		4.03
4.04	926,684	0		4.04
4.05	-721,820	0		4.05
4.06	-7,063	0		4.06
4.07	-23,151	0		4.07
4.08	-540,645	0		4.08
4.09	-450,558	0		4.09
4.10	-221,927	0		4.10
4.11	-21,475	0		4.11
4.12	-145,485	0		4.12
4.13	-21,545	0		4.13
4.14	-10,848	0		4.14
4.17	-4,709	14		4.17
5.00	-385,208			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2018 4:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	23,553	23,553	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	41,998	810	41,188	211,500	335	2.00
3.00	30.00	ADULTS & PEDIATRICS	800,120	800,120	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	43,519	43,519	0	0	0	5.00
6.00	91.00	EMERGENCY	208,902	208,902	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,118,092	1,076,904	41,188		335	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	34,064	1,703	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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			34,064	1,703	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	23,553		1.00
2.00	13.00	NURSING ADMINISTRATION	0	34,064	7,124	7,934		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	800,120		3.00
4.00	0.00		0	0	0	0		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	43,519		5.00
6.00	91.00	EMERGENCY	0	0	0	208,902		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	34,064	7,124	1,084,028		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,747,180	1,747,180				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	0	0			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,481,430			2,481,430		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,701,572	0	0	16,695	2,718,267	4.00
5.01	01160	COMMUNICATIONS	453,403	8,771	0	10,717	9,584	5.01
5.02	00540	ADMITTING	423,801	11,627	0	14,206	78,433	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	880,953	17,124	0	20,923	22,237	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	4,905,273	144,358	0	184,732	205,861	5.04
7.00	00700	OPERATION OF PLANT	1,872,569	101,268	0	123,735	77,701	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,407	1,708	0	31,868	0	8.00
9.00	00900	HOUSEKEEPING	365,177	7,214	0	8,815	48,043	9.00
10.00	01000	DIETARY	313,902	70,871	0	86,595	37,266	10.00
11.00	01100	CAFETERIA	402,537	0	0	38,346	51,816	11.00
13.00	01300	NURSING ADMINISTRATION	1,097,100	3,558	0	4,348	210,979	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	559,781	87,871	0	107,366	30,690	14.00
15.00	01500	PHARMACY	750,312	0	0	0	111,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	548,964	20,887	0	25,521	60,475	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,596,517	148,388	0	181,309	294,269	30.00
31.00	03100	INTENSIVE CARE UNIT	738,245	26,144	0	31,944	141,683	31.00
43.00	04300	NURSERY	291,167	4,350	0	5,315	43,951	43.00
44.00	04400	SKILLED NURSING FACILITY	778,152	53,080	0	64,856	143,230	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,365,120	139,652	0	170,635	214,719	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	478,216	5,124	0	6,261	72,186	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,088,121	97,220	0	118,789	198,865	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	136,930	6,334	0	7,739	12,699	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,622,295	40,262	0	49,194	154,874	60.00
65.00	06500	RESPIRATORY THERAPY	369,838	47,227	0	57,704	70,824	65.00
66.00	06600	PHYSICAL THERAPY	880,896	43,829	0	53,552	171,096	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	184,135	0	0	14,086	36,801	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	184,937	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	665,488	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,001,117	13,032	0	31,847	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	121,172	3,087	0	3,772	21,884	76.01
76.03	03953	WOUND CARE	46,283	0	0	0	6,809	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	59,261	9,554	0	11,673	10,058	90.00
91.00	09100	EMERGENCY	939,891	42,325	0	51,715	160,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,169,142	1,154,865	0	1,534,258	2,699,120	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,833	8,211	0	10,032	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	533,150	0	828,904	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	31,499	0	38,488	0	194.00
194.01	07955	MARKETING	232,125	19,455	0	23,771	17,856	194.01
194.02	07952	SENIOR CIRCLE	8,741	0	0	0	1,291	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	45,977	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers			0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,435,841	1,747,180	0	2,481,430	2,718,267	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	COMMUNICATIONS	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	482,475					5.01
5.02	00540	ADMITTING	7,874	535,941	535,941			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	5,727	946,964	15,910	962,874	962,874	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	37,224	5,477,448	92,013	5,569,461	170,381	5.04
7.00	00700	OPERATION OF PLANT	8,590	2,183,863	36,691	2,220,554	67,936	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	716	151,699	2,549	154,248	4,719	8.00
9.00	00900	HOUSEKEEPING	1,432	430,681	7,236	437,917	13,398	9.00
10.00	01000	DIETARY	6,443	515,077	8,654	523,731	16,023	10.00
11.00	01100	CAFETERIA	0	492,699	8,278	500,977	15,327	11.00
13.00	01300	NURSING ADMINISTRATION	2,148	1,318,133	22,146	1,340,279	41,004	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,579	789,287	13,261	802,548	24,553	14.00
15.00	01500	PHARMACY	7,874	869,509	14,609	884,118	27,049	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,896	673,743	11,320	685,063	20,959	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,317	2,234,800	37,547	2,272,347	69,520	30.00
31.00	03100	INTENSIVE CARE UNIT	3,579	941,595	15,820	957,415	29,291	31.00
43.00	04300	NURSERY	716	345,499	5,805	351,304	10,748	43.00
44.00	04400	SKILLED NURSING FACILITY	7,158	1,046,476	17,582	1,064,058	32,554	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,339	1,914,465	32,165	1,946,630	59,555	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,432	563,219	9,463	572,682	17,521	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,033	1,518,028	25,504	1,543,532	47,223	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	1,432	165,134	2,774	167,908	5,137	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	13,601	1,880,226	31,590	1,911,816	58,490	60.00
65.00	06500	RESPIRATORY THERAPY	2,148	547,741	9,203	556,944	17,039	65.00
66.00	06600	PHYSICAL THERAPY	3,579	1,152,952	19,371	1,172,323	35,866	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	4,295	239,317	4,021	243,338	7,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	184,937	3,107	188,044	5,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	665,488	11,181	676,669	20,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,045,996	17,574	1,063,570	32,539	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	149,915	2,519	152,434	4,664	76.01
76.03	03953	WOUND CARE	0	53,092	892	53,984	1,652	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,579	94,125	1,581	95,706	2,928	90.00
91.00	09100	EMERGENCY	12,169	1,206,864	20,277	1,227,141	37,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206,880	30,334,913	500,643	30,299,615	897,519	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,863	46,939	789	47,728	1,460	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	272,732	1,634,786	27,466	1,662,252	50,855	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	69,987	1,176	71,163	2,177	194.00
194.01	07955	MARKETING	0	293,207	4,926	298,133	9,121	194.01
194.02	07952	SENIOR CIRCLE	0	10,032	169	10,201	312	194.02
194.03	07953	BUSINESS HEALTH	0	45,977	772	46,749	1,430	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	482,475	32,435,841	535,941	32,435,841	962,874	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.03	5.04	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,739,842	5,739,842				5.04
7.00	00700	OPERATION OF PLANT	2,288,490	492,044	2,780,534			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	158,967	34,179	41,987	235,133		8.00
9.00	00900	HOUSEKEEPING	451,315	97,036	11,614	0	559,965	9.00
10.00	01000	DIETARY	539,754	116,051	114,091	0	23,428	10.00
11.00	01100	CAFETERIA	516,304	111,009	50,522	0	10,375	11.00
13.00	01300	NURSING ADMINISTRATION	1,381,283	296,987	5,728	0	1,176	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	827,101	177,833	141,457	10,183	29,048	14.00
15.00	01500	PHARMACY	911,167	195,908	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	706,022	151,800	33,624	0	6,905	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,341,867	503,512	238,879	75,492	49,053	30.00
31.00	03100	INTENSIVE CARE UNIT	986,706	212,150	42,088	12,984	8,643	31.00
43.00	04300	NURSERY	362,052	77,844	7,003	0	1,438	43.00
44.00	04400	SKILLED NURSING FACILITY	1,096,612	235,780	85,450	32,348	17,547	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,006,185	431,346	224,816	42,778	46,165	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	590,203	126,898	8,249	0	1,694	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,590,755	342,025	156,508	23,640	32,138	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	173,045	37,206	10,196	0	2,094	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,970,306	423,632	64,814	0	13,309	60.00
65.00	06500	RESPIRATORY THERAPY	573,983	123,411	76,027	1,000	15,612	65.00
66.00	06600	PHYSICAL THERAPY	1,208,189	259,770	70,557	1,677	14,489	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	250,783	53,920	18,559	0	3,811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	193,797	41,668	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	697,371	149,940	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,096,109	235,672	41,959	0	8,616	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	157,098	33,777	4,969	0	1,020	76.01
76.03	03953	WOUND CARE	55,636	11,962	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	98,634	21,207	15,380	0	3,158	90.00
91.00	09100	EMERGENCY	1,264,684	271,917	68,136	35,031	13,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,234,260	5,266,484	1,532,613	235,133	303,711	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,188	10,576	13,218	0	2,714	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,713,107	368,332	1,092,100	0	224,257	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	73,340	15,769	50,709	0	10,413	194.00
194.01	07955	MARKETING	307,254	66,062	31,319	0	6,431	194.01
194.02	07952	SENIOR CIRCLE	10,513	2,260	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	48,179	10,359	60,575	0	12,439	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,435,841	5,739,842	2,780,534	235,133	559,965	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	793,324					10.00
11.00	01100	CAFETERIA	0	688,210				11.00
13.00	01300	NURSING ADMINISTRATION	0	47,470	1,732,644			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,985	0	1,201,607		14.00
15.00	01500	PHARMACY	0	26,102	0	42,541	1,175,718	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,449	0	1,043	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	426,485	101,818	473,145	85,113	0	30.00
31.00	03100	INTENSIVE CARE UNIT	52,893	39,295	227,805	17,008	0	31.00
43.00	04300	NURSERY	0	11,979	70,667	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	313,946	53,500	230,292	15,647	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	66,369	345,236	146,012	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,668	116,065	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,882	0	44,629	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	3,237	0	31,805	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	60,703	0	222,944	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,177	0	7,580	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,158	0	10,233	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	21,125	0	93	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	107,037	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	387,837	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,175,718	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	6,192	0	2,495	0	76.01
76.03	03953	WOUND CARE	0	2,630	10,948	6,982	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,740	0	5,116	0	90.00
91.00	09100	EMERGENCY	0	46,337	258,486	50,869	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	793,324	681,816	1,732,644	1,184,984	1,175,718	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,908	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	5,908	0	1,676	0	194.01
194.02	07952	SENIOR CIRCLE	0	486	0	39	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	793,324	688,210	1,732,644	1,201,607	1,175,718	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	927,843					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,691	4,350,055	0	4,350,055		30.00
31.00	03100	INTENSIVE CARE UNIT	13,303	1,612,875	0	1,612,875		31.00
43.00	04300	NURSERY	3,742	534,725	0	534,725		43.00
44.00	04400	SKILLED NURSING FACILITY	17,125	2,098,247	0	2,098,247		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	182,370	3,491,277	0	3,491,277		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,146	868,923	0	868,923		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,934	2,405,511	0	2,405,511		54.00
54.01	03630	ULTRA SOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	6,184	263,767	0	263,767		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	201,909	2,957,617	0	2,957,617		60.00
65.00	06500	RESPIRATORY THERAPY	15,455	835,245	0	835,245		65.00
66.00	06600	PHYSICAL THERAPY	35,030	1,648,103	0	1,648,103		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	11,712	360,003	0	360,003		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,070	383,572	0	383,572		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,033	1,262,181	0	1,262,181		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,812	2,630,886	0	2,630,886		73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03951	SLEEP LAB	3,151	208,702	0	208,702		76.01
76.03	03953	WOUND CARE	1,433	89,591	0	89,591		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,786	147,021	0	147,021		90.00
91.00	09100	EMERGENCY	75,957	2,085,409	0	2,085,409		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	927,843	28,233,710	0	28,233,710		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	90,604	0	90,604		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,397,796	0	3,397,796		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	150,231	0	150,231		194.00
194.01	07955	MARKETING	0	418,650	0	418,650		194.01
194.02	07952	SENIOR CIRCLE	0	13,298	0	13,298		194.02
194.03	07953	BUSINESS HEALTH	0	131,552	0	131,552		194.03
194.04	07954	VACANT SPACE	0	0	0	0		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	927,843	32,435,841	0	32,435,841		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS WELLS CRC COSTS-BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	16,695	16,695	4.00
5.01	01160	COMMUNICATIONS	0	8,771	0	10,717	19,488	5.01
5.02	00540	ADMITTING	0	11,627	0	14,206	25,833	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	17,124	0	20,923	38,047	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	144,358	0	184,732	329,090	5.04
7.00	00700	OPERATION OF PLANT	0	101,268	0	123,735	225,003	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,708	0	31,868	33,576	8.00
9.00	00900	HOUSEKEEPING	0	7,214	0	8,815	16,029	9.00
10.00	01000	DIETARY	0	70,871	0	86,595	157,466	10.00
11.00	01100	CAFETERIA	0	0	0	38,346	38,346	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,558	0	4,348	7,906	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87,871	0	107,366	195,237	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,887	0	25,521	46,408	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	148,388	0	181,309	329,697	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,144	0	31,944	58,088	31.00
43.00	04300	NURSERY	0	4,350	0	5,315	9,665	43.00
44.00	04400	SKILLED NURSING FACILITY	0	53,080	0	64,856	117,936	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	139,652	0	170,635	310,287	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,124	0	6,261	11,385	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,220	0	118,789	216,009	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	6,334	0	7,739	14,073	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	40,262	0	49,194	89,456	60.00
65.00	06500	RESPIRATORY THERAPY	0	47,227	0	57,704	104,931	65.00
66.00	06600	PHYSICAL THERAPY	0	43,829	0	53,552	97,381	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	14,086	14,086	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	13,032	0	31,847	44,879	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	3,087	0	3,772	6,859	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,554	0	11,673	21,227	90.00
91.00	09100	EMERGENCY	0	42,325	0	51,715	94,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,154,865	0	1,534,258	2,689,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,211	0	10,032	18,243	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	533,150	0	828,904	1,362,054	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	31,499	0	38,488	69,987	194.00
194.01	07955	MARKETING	0	19,455	0	23,771	43,226	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	45,977	45,977	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,747,180	0	2,481,430	4,228,610	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,695					4.00
5.01	01160	COMMUNICATIONS	59	19,547				5.01
5.02	00540	ADMITTING	482	319	26,634			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	137	232	791	39,207		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,265	1,508	4,571	6,931	343,365	5.04
7.00	00700	OPERATION OF PLANT	477	348	1,824	2,767	29,435	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29	127	192	2,045	8.00
9.00	00900	HOUSEKEEPING	295	58	360	546	5,805	9.00
10.00	01000	DIETARY	229	261	430	653	6,942	10.00
11.00	01100	CAFETERIA	318	0	411	624	6,641	11.00
13.00	01300	NURSING ADMINISTRATION	1,296	87	1,101	1,670	17,766	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	189	145	659	1,000	10,638	14.00
15.00	01500	PHARMACY	684	319	726	1,102	11,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	372	725	563	854	9,081	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,803	580	1,866	2,831	30,118	30.00
31.00	03100	INTENSIVE CARE UNIT	870	145	786	1,193	12,691	31.00
43.00	04300	NURSERY	270	29	288	438	4,657	43.00
44.00	04400	SKILLED NURSING FACILITY	880	290	874	1,326	14,105	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,319	986	1,599	2,426	25,804	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	443	58	470	714	7,591	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,222	609	1,268	1,923	20,460	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	78	58	138	209	2,226	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	951	551	1,570	2,382	25,342	60.00
65.00	06500	RESPIRATORY THERAPY	435	87	457	694	7,383	65.00
66.00	06600	PHYSICAL THERAPY	1,051	145	963	1,461	15,540	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	226	174	200	303	3,226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	154	234	2,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	556	843	8,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	873	1,325	14,098	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	134	0	125	190	2,021	76.01
76.03	03953	WOUND CARE	42	0	44	67	716	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62	145	79	119	1,269	90.00
91.00	09100	EMERGENCY	988	493	1,008	1,529	16,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,577	8,381	24,881	36,546	315,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116	39	59	633	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,050	1,365	2,071	22,034	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	58	89	943	194.00
194.01	07955	MARKETING	110	0	245	371	3,952	194.01
194.02	07952	SENIOR CIRCLE	8	0	8	13	135	194.02
194.03	07953	BUSINESS HEALTH	0	0	38	58	620	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,695	19,547	26,634	39,207	343,365	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 4:19 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
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	259,854					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,924	39,893				8.00
9.00	00900	HOUSEKEEPING	1,085	0	24,178			9.00
10.00	01000	DIETARY	10,662	0	1,012	177,655		10.00
11.00	01100	CAFETERIA	4,722	0	448	0	51,510	11.00
13.00	01300	NURSING ADMINISTRATION	535	0	51	0	3,553	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,220	1,728	1,254	0	1,196	14.00
15.00	01500	PHARMACY	0	0	0	0	1,954	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,142	0	298	0	2,129	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,324	12,808	2,118	95,506	7,624	30.00
31.00	03100	INTENSIVE CARE UNIT	3,933	2,203	373	11,845	2,941	31.00
43.00	04300	NURSERY	654	0	62	0	897	43.00
44.00	04400	SKILLED NURSING FACILITY	7,986	5,488	758	70,304	4,004	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,010	7,258	1,993	0	4,967	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	771	0	73	0	1,472	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,626	4,011	1,388	0	4,407	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	953	0	90	0	242	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	6,057	0	575	0	4,543	60.00
65.00	06500	RESPIRATORY THERAPY	7,105	170	674	0	1,660	65.00
66.00	06600	PHYSICAL THERAPY	6,594	284	626	0	3,604	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	1,734	0	165	0	1,581	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	3,921	0	372	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	464	0	44	0	463	76.01
76.03	03953	WOUND CARE	0	0	0	0	197	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,437	0	136	0	130	90.00
91.00	09100	EMERGENCY	6,368	5,943	604	0	3,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,227	39,893	13,114	177,655	51,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,235	0	117	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,065	0	9,682	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	4,739	0	450	0	0	194.00
194.01	07955	MARKETING	2,927	0	278	0	442	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	36	194.02
194.03	07953	BUSINESS HEALTH	5,661	0	537	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	259,854	39,893	24,178	177,655	51,510	202.00

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		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	33,965					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	225,266				14.00
15.00	01500	PHARMACY	0	7,975	24,479			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	195	0	63,767		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,274	15,956	0	3,758	536,263	30.00
31.00	03100	INTENSIVE CARE UNIT	4,466	3,188	0	914	103,636	31.00
43.00	04300	NURSERY	1,385	0	0	257	18,602	43.00
44.00	04400	SKILLED NURSING FACILITY	4,515	2,933	0	1,177	232,576	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,768	27,373	0	12,533	424,323	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,275	0	0	422	25,674	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,367	0	10,785	285,075	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	5,963	0	425	24,455	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	41,796	0	13,879	187,102	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,421	0	1,062	126,079	65.00
66.00	06600	PHYSICAL THERAPY	0	1,918	0	2,407	131,974	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	17	0	805	22,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,066	0	2,822	25,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72,710	0	1,858	84,937	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,479	5,004	94,951	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	468	0	217	10,985	76.01
76.03	03953	WOUND CARE	215	1,309	0	99	2,689	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	959	0	123	25,686	90.00
91.00	09100	EMERGENCY	5,067	9,536	0	5,220	150,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,965	222,150	24,479	63,767	2,513,823	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,795	0	0	23,237	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,510,321	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	76,266	194.00
194.01	07955	MARKETING	0	314	0	0	51,865	194.01
194.02	07952	SENIOR CIRCLE	0	7	0	0	207	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	52,891	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,965	225,266	24,479	63,767	4,228,610	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01160	COMMUNICATIONS				5.01
5.02	00540	ADMITTING				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	536,263		30.00
31.00	03100	INTENSIVE CARE UNIT	0	103,636		31.00
43.00	04300	NURSERY	0	18,602		43.00
44.00	04400	SKILLED NURSING FACILITY	0	232,576		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	424,323		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,674		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	285,075		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	24,455		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	187,102		60.00
65.00	06500	RESPIRATORY THERAPY	0	126,079		65.00
66.00	06600	PHYSICAL THERAPY	0	131,974		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	22,517		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,769		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,937		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	94,951		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	10,985		76.01
76.03	03953	WOUND CARE	0	2,689		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	25,686		90.00
91.00	09100	EMERGENCY	0	150,530		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,513,823		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,237		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,510,321		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	76,266		194.00
194.01	07955	MARKETING	0	51,865		194.01
194.02	07952	SENIOR CIRCLE	0	207		194.02
194.03	07953	BUSINESS HEALTH	0	52,891		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,228,610		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	196,409					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			228,300			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,536	1,536	12,622,386		4.00
5.01	01160	COMMUNICATIONS	986	0	986	44,504	674	5.01
5.02	00540	ADMITTING	1,307	0	1,307	364,205	11	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	1,925	103,258	8	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	16,228	768	16,996	955,924	52	5.04
7.00	00700	OPERATION OF PLANT	11,384	0	11,384	360,807	12	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1	8.00
9.00	00900	HOUSEKEEPING	811	0	811	223,088	2	9.00
10.00	01000	DIETARY	7,967	0	7,967	173,048	9	10.00
11.00	01100	CAFETERIA	0	3,528	3,528	240,608	0	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	979,689	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	142,509	5	14.00
15.00	01500	PHARMACY	0	0	0	516,933	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	280,816	25	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,366,460	20	30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	657,910	5	31.00
43.00	04300	NURSERY	489	0	489	204,090	1	43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	665,092	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	0	15,699	997,055	34	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	335,200	2	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	923,436	21	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	712	0	712	58,966	2	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,526	0	4,526	719,162	19	60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	328,876	3	65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	794,493	5	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	1,296	1,296	170,885	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	1,465	1,465	2,930	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	347	0	347	101,621	0	76.01
76.03	03953	WOUND CARE	0	0	0	31,619	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,074	0	1,074	46,705	5	90.00
91.00	09100	EMERGENCY	4,758	0	4,758	746,516	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,824	11,333	141,157	12,533,475	289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0	194.00
194.01	07955	MARKETING	2,187	0	2,187	82,914	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	5,997	0	194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	0	0	194.03
194.04	07954	VACANT SPACE	0	88,106	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,747,180	0	2,481,430	2,718,267	482,475	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.895621	0.000000	10.869163	0.215353	715.838279	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				16,695	19,547	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001323	29.001484	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
			5A.02	5.02	5A.03	5.03	5A.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	-535,941	31,899,900				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	946,964	-962,874	31,472,967		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	5,477,448	0	5,569,461	-5,739,842	5.04
7.00	00700	OPERATION OF PLANT	0	2,183,863	0	2,220,554	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	151,699	0	154,248	0	8.00
9.00	00900	HOUSEKEEPING	0	430,681	0	437,917	0	9.00
10.00	01000	DIETARY	0	515,077	0	523,731	0	10.00
11.00	01100	CAFETERIA	0	492,699	0	500,977	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,318,133	0	1,340,279	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	789,287	0	802,548	0	14.00
15.00	01500	PHARMACY	0	869,509	0	884,118	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	673,743	0	685,063	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,234,800	0	2,272,347	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	941,595	0	957,415	0	31.00
43.00	04300	NURSERY	0	345,499	0	351,304	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,046,476	0	1,064,058	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,914,465	0	1,946,630	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	563,219	0	572,682	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,518,028	0	1,543,532	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	165,134	0	167,908	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,880,226	0	1,911,816	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	547,741	0	556,944	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,152,952	0	1,172,323	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	239,317	0	243,338	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	184,937	0	188,044	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	665,488	0	676,669	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,045,996	0	1,063,570	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	149,915	0	152,434	0	76.01
76.03	03953	WOUND CARE	0	53,092	0	53,984	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	94,125	0	95,706	0	90.00
91.00	09100	EMERGENCY	0	1,206,864	0	1,227,141	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-535,941	29,798,972	-962,874	29,336,741	-5,739,842	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,939	0	47,728	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,634,786	0	1,662,252	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	69,987	0	71,163	0	194.00
194.01	07955	MARKETING	0	293,207	0	298,133	0	194.01
194.02	07952	SENIOR CIRCLE	0	10,032	0	10,201	0	194.02
194.03	07953	BUSINESS HEALTH	0	45,977	0	46,749	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)		535,941		962,874		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.016801		0.030594		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		26,634		39,207		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000835		0.001246		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.04	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	26,695,999					5.04
7.00	00700	OPERATION OF PLANT	2,288,490	194,166				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	158,967	2,932	268,415			8.00
9.00	00900	HOUSEKEEPING	451,315	811	0	190,423		9.00
10.00	01000	DIETARY	539,754	7,967	0	7,967	32,547	10.00
11.00	01100	CAFETERIA	516,304	3,528	0	3,528	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,381,283	400	0	400	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	827,101	9,878	11,624	9,878	0	14.00
15.00	01500	PHARMACY	911,167	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	706,022	2,348	0	2,348	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,341,867	16,681	86,177	16,681	17,497	30.00
31.00	03100	INTENSIVE CARE UNIT	986,706	2,939	14,822	2,939	2,170	31.00
43.00	04300	NURSERY	362,052	489	0	489	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,096,612	5,967	36,927	5,967	12,880	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,006,185	15,699	48,833	15,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	590,203	576	0	576	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,590,755	10,929	26,986	10,929	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	173,045	712	0	712	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,970,306	4,526	0	4,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	573,983	5,309	1,142	5,309	0	65.00
66.00	06600	PHYSICAL THERAPY	1,208,189	4,927	1,914	4,927	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	250,783	1,296	0	1,296	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	193,797	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	697,371	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,096,109	2,930	0	2,930	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	157,098	347	0	347	0	76.01
76.03	03953	WOUND CARE	55,636	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	98,634	1,074	0	1,074	0	90.00
91.00	09100	EMERGENCY	1,264,684	4,758	39,990	4,758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,494,418	107,023	268,415	103,280	32,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,188	923	0	923	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,713,107	76,262	0	76,262	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	73,340	3,541	0	3,541	0	194.00
194.01	07955	MARKETING	307,254	2,187	0	2,187	0	194.01
194.02	07952	SENIOR CIRCLE	10,513	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	48,179	4,230	0	4,230	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,739,842	2,780,534	235,133	559,965	793,324	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.215008	14.320396	0.876005	2.940637	24.374720	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	343,365	259,854	39,893	24,178	177,655	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.012862	1.338308	0.148624	0.126970	5.458414	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 4:19 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	17,006					11.00
13.00	01300	NURSING ADMINISTRATION	1,173	5,003,942				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	395	0	2,061,826			14.00
15.00	01500	PHARMACY	645	0	72,995	1,001,117		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	703	0	1,789	0	192,076,449	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,516	1,366,460	146,044	0	11,320,749	30.00
31.00	03100	INTENSIVE CARE UNIT	971	657,910	29,183	0	2,753,651	31.00
43.00	04300	NURSERY	296	204,090	0	0	774,628	43.00
44.00	04400	SKILLED NURSING FACILITY	1,322	665,092	26,849	0	3,544,863	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,640	997,055	250,540	0	37,749,879	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	486	335,200	0	0	1,272,260	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,455	0	76,578	0	32,484,720	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	80	0	54,574	0	1,280,162	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,500	0	382,548	0	41,810,859	60.00
65.00	06500	RESPIRATORY THERAPY	548	0	13,007	0	3,199,123	65.00
66.00	06600	PHYSICAL THERAPY	1,190	0	17,558	0	7,251,049	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	522	0	160	0	2,424,354	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	183,664	0	8,501,333	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	665,488	0	5,595,634	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,001,117	15,071,766	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	153	0	4,282	0	652,151	76.01
76.03	03953	WOUND CARE	65	31,619	11,981	0	296,719	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43	0	8,778	0	369,754	90.00
91.00	09100	EMERGENCY	1,145	746,516	87,285	0	15,722,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,848	5,003,942	2,033,303	1,001,117	192,076,449	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	25,581	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	146	0	2,875	0	0	194.01
194.02	07952	SENIOR CIRCLE	12	0	67	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	688,210	1,732,644	1,201,607	1,175,718	927,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.468658	0.346256	0.582788	1.174406	0.004831	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,510	33,965	225,266	24,479	63,767	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.028931	0.006788	0.109256	0.024452	0.000332	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,350,055		4,350,055	0	4,350,055	30.00
31.00	03100	INTENSIVE CARE UNIT	1,612,875		1,612,875	0	1,612,875	31.00
43.00	04300	NURSERY	534,725		534,725	0	534,725	43.00
44.00	04400	SKILLED NURSING FACILITY	2,098,247		2,098,247	0	2,098,247	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,491,277		3,491,277	0	3,491,277	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	868,923		868,923	0	868,923	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,405,511		2,405,511	0	2,405,511	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	263,767		263,767	0	263,767	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,957,617		2,957,617	0	2,957,617	60.00
65.00	06500	RESPIRATORY THERAPY	835,245	0	835,245	0	835,245	65.00
66.00	06600	PHYSICAL THERAPY	1,648,103	0	1,648,103	0	1,648,103	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	360,003		360,003	0	360,003	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	383,572		383,572	0	383,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,262,181		1,262,181	0	1,262,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,630,886		2,630,886	0	2,630,886	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	208,702		208,702	0	208,702	76.01
76.03	03953	WOUND CARE	89,591		89,591	0	89,591	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	147,021		147,021	0	147,021	90.00
91.00	09100	EMERGENCY	2,085,409		2,085,409	0	2,085,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	851,805		851,805		851,805	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	29,085,515	0	29,085,515	0	29,085,515	200.00
201.00		Less Observation Beds	851,805		851,805		851,805	201.00
202.00		Total (see instructions)	28,233,710	0	28,233,710	0	28,233,710	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,079,201		9,079,201			30.00
31.00	03100	INTENSIVE CARE UNIT	2,753,651		2,753,651			31.00
43.00	04300	NURSERY	774,628		774,628			43.00
44.00	04400	SKILLED NURSING FACILITY	3,544,863		3,544,863			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,022,079	29,727,800	37,749,879	0.092484	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	890,583	381,677	1,272,260	0.682976	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,973,074	27,511,646	32,484,720	0.074051	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	135,222	1,144,940	1,280,162	0.206042	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	10,635,092	31,175,767	41,810,859	0.070738	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,908,058	291,065	3,199,123	0.261086	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,908,141	3,342,908	7,251,049	0.227292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	938,453	1,485,901	2,424,354	0.148494	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,179,606	4,321,727	8,501,333	0.045119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,131,614	2,464,020	5,595,634	0.225565	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,961,685	8,110,081	15,071,766	0.174557	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	652,151	652,151	0.320021	0.000000	76.01
76.03	03953	WOUND CARE	0	296,719	296,719	0.301939	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	53,824	315,930	369,754	0.397618	0.000000	90.00
91.00	09100	EMERGENCY	2,913,270	12,809,525	15,722,795	0.132636	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	340,650	1,900,898	2,241,548	0.380007	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	66,143,694	125,932,755	192,076,449			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,143,694	125,932,755	192,076,449			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.092484
51.00	05100	RECOVERY ROOM	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682976
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074051
54.01	03630	ULTRA SOUND	0.000000
56.00	05600	RADIOISOTOPE	0.206042
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.070738
65.00	06500	RESPIRATORY THERAPY	0.261086
66.00	06600	PHYSICAL THERAPY	0.227292
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.148494
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045119
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225565
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174557
76.00	03950	OTHER ANCILLARY	0.000000
76.01	03951	SLEEP LAB	0.320021
76.03	03953	WOUND CARE	0.301939
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.397618
91.00	09100	EMERGENCY	0.132636
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380007
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,350,055		4,350,055	0	4,350,055	30.00
31.00	03100	INTENSIVE CARE UNIT	1,612,875		1,612,875	0	1,612,875	31.00
43.00	04300	NURSERY	534,725		534,725	0	534,725	43.00
44.00	04400	SKILLED NURSING FACILITY	2,098,247		2,098,247	0	2,098,247	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,491,277		3,491,277	0	3,491,277	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	868,923		868,923	0	868,923	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,405,511		2,405,511	0	2,405,511	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	263,767		263,767	0	263,767	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,957,617		2,957,617	0	2,957,617	60.00
65.00	06500	RESPIRATORY THERAPY	835,245	0	835,245	0	835,245	65.00
66.00	06600	PHYSICAL THERAPY	1,648,103	0	1,648,103	0	1,648,103	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	360,003		360,003	0	360,003	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	383,572		383,572	0	383,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,262,181		1,262,181	0	1,262,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,630,886		2,630,886	0	2,630,886	73.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	208,702		208,702	0	208,702	76.01
76.03	03953	WOUND CARE	89,591		89,591	0	89,591	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	147,021		147,021	0	147,021	90.00
91.00	09100	EMERGENCY	2,085,409		2,085,409	0	2,085,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	851,805		851,805		851,805	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	29,085,515	0	29,085,515	0	29,085,515	200.00
201.00		Less Observation Beds	851,805		851,805		851,805	201.00
202.00		Total (see instructions)	28,233,710	0	28,233,710	0	28,233,710	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,079,201		9,079,201			30.00
31.00	03100	INTENSIVE CARE UNIT	2,753,651		2,753,651			31.00
43.00	04300	NURSERY	774,628		774,628			43.00
44.00	04400	SKILLED NURSING FACILITY	3,544,863		3,544,863			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,022,079	29,727,800	37,749,879	0.092484	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	890,583	381,677	1,272,260	0.682976	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,973,074	27,511,646	32,484,720	0.074051	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	135,222	1,144,940	1,280,162	0.206042	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	10,635,092	31,175,767	41,810,859	0.070738	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,908,058	291,065	3,199,123	0.261086	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,908,141	3,342,908	7,251,049	0.227292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	938,453	1,485,901	2,424,354	0.148494	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,179,606	4,321,727	8,501,333	0.045119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,131,614	2,464,020	5,595,634	0.225565	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,961,685	8,110,081	15,071,766	0.174557	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	652,151	652,151	0.320021	0.000000	76.01
76.03	03953	WOUND CARE	0	296,719	296,719	0.301939	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	53,824	315,930	369,754	0.397618	0.000000	90.00
91.00	09100	EMERGENCY	2,913,270	12,809,525	15,722,795	0.132636	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	340,650	1,900,898	2,241,548	0.380007	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	66,143,694	125,932,755	192,076,449			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,143,694	125,932,755	192,076,449			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.01	03951	SLEEP LAB	0.000000		76.01
76.03	03953	WOUND CARE	0.000000		76.03
		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			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	536,263	0	536,263	4,397	121.96	30.00
31.00	INTENSIVE CARE UNIT	103,636		103,636	748	138.55	31.00
43.00	NURSERY	18,602		18,602	461	40.35	43.00
44.00	SKILLED NURSING FACILITY	232,576		232,576	3,232	71.96	44.00
200.00	Total (lines 30 through 199)	891,077		891,077	8,838		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	1,697	206,966				30.00
31.00	INTENSIVE CARE UNIT	312	43,228				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	1,562	112,402				44.00
200.00	Total (lines 30 through 199)	3,571	362,596				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	424,323	37,749,879	0.011240	2,358,128	26,505	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,674	1,272,260	0.020180	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	285,075	32,484,720	0.008776	2,335,332	20,495	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	24,455	1,280,162	0.019103	74,504	1,423	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	187,102	41,810,859	0.004475	4,495,444	20,117	60.00
65.00	06500	RESPIRATORY THERAPY	126,079	3,199,123	0.039410	1,205,247	47,499	65.00
66.00	06600	PHYSICAL THERAPY	131,974	7,251,049	0.018201	306,622	5,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,517	2,424,354	0.009288	921,163	8,556	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,769	8,501,333	0.003031	1,439,221	4,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,937	5,595,634	0.015179	1,336,713	20,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,951	15,071,766	0.006300	2,040,221	12,853	73.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	10,985	652,151	0.016844	0	0	76.01
76.03	03953	WOUND CARE	2,689	296,719	0.009062	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,686	369,754	0.069468	11,283	784	90.00
91.00	09100	EMERGENCY	150,530	15,722,795	0.009574	1,414,001	13,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	105,008	2,241,548	0.046846	185,440	8,687	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,727,754	175,924,106		18,123,319	190,690	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,397	0.00	1,697	30.00
31.00	03100	INTENSIVE CARE UNIT		0	748	0.00	312	31.00
43.00	04300	NURSERY		0	461	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	3,232	0.00	1,562	44.00
200.00		Total (lines 30 through 199)		0	8,838		3,571	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	37,749,879	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,272,260	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,484,720	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,280,162	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	41,810,859	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,199,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,251,049	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,424,354	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,501,333	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,595,634	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,071,766	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	652,151	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	296,719	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	369,754	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,722,795	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,241,548	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	175,924,106		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,358,128	0	7,283,202	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	458	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,335,332	0	6,677,094	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	74,504	0	468,222	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	4,495,444	0	2,902,640	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,205,247	0	85,753	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	306,622	0	29,805	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	921,163	0	752,476	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,439,221	0	897,229	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,336,713	0	728,426	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,040,221	0	3,415,398	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	97,602	0	76.01
76.03	03953	WOUND CARE	0.000000	0	0	38,719	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	11,283	0	82,522	0	90.00
91.00	09100	EMERGENCY	0.000000	1,414,001	0	2,677,940	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	185,440	0	535,440	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		18,123,319	0	26,672,926	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.092484	7,283,202	0	0	673,580	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682976	458	0	0	313	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074051	6,677,094	0	0	494,445	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.206042	468,222	0	0	96,473	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.070738	2,902,640	0	0	205,327	60.00
65.00	06500	RESPIRATORY THERAPY	0.261086	85,753	0	0	22,389	65.00
66.00	06600	PHYSICAL THERAPY	0.227292	29,805	0	0	6,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148494	752,476	0	0	111,738	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045119	897,229	0	0	40,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225565	728,426	0	0	164,307	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174557	3,415,398	0	5,123	596,182	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.320021	97,602	0	0	31,235	76.01
76.03	03953	WOUND CARE	0.301939	38,719	0	0	11,691	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.397618	82,522	0	186	32,812	90.00
91.00	09100	EMERGENCY	0.132636	2,677,940	0	0	355,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380007	535,440	0	0	203,471	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		26,672,926	0	5,309	3,046,410	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		26,672,926	0	5,309	3,046,410	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	894		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	74		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	968		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	968		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	37,749,879	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,272,260	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,484,720	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,280,162	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	41,810,859	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,199,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,251,049	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,424,354	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,501,333	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,595,634	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,071,766	0.000000	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	652,151	0.000000	76.01
76.03	03953	WOUND CARE	0	0	0	296,719	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	369,754	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,722,795	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,241,548	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	175,924,106		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	34,945	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	283,401	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	264,962	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,599,063	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,151	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	211,141	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	706,705	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,108,368	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.092484	0	177,315	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682976	0	5,799	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074051	0	281,840	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.206042	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.070738	0	343,425	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.261086	0	5,650	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.227292	0	190,519	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148494	0	12,508	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045119	0	7,217	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225565	0	20,903	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174557	0	56,540	0	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.320021	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.301939	0	373	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.397618	0	967	0	0	90.00
91.00	09100	EMERGENCY	0.132636	0	280,066	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380007	0	16,441	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,399,563	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,399,563	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	16,399	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,961	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,871	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	24,293	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,475	0		65.00
66.00	06600	PHYSICAL THERAPY	43,303	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	1,857	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	326	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,715	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,869	0		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	113	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	384	0		90.00
91.00	09100	EMERGENCY	37,147	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,248	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	170,961	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	170,961	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 4:19 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,397	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,397	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.	1,092	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,444	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,697	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,350,055	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,350,055	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	9,853,829	28.00
29.00	Private room charges (excluding swing-bed charges)	2,518,041	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	7,335,788	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.441458	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,305.90	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	3,001.55	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,350,055	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)	989.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,678,876	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,678,876	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,612,875	748	2,156.25	312	672,750	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,230,614	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,582,240	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)	250,194	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	190,690	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	440,884	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,141,356	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)	861	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	989.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	851,805	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	536,263	4,350,055	0.123277	851,805	105,008	90.00
91.00	Nursing School cost	0	4,350,055	0.000000	851,805	0	91.00
92.00	Allied health cost	0	4,350,055	0.000000	851,805	0	92.00
93.00	All other Medical Education	0	4,350,055	0.000000	851,805	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 4:19 pm
	Title XVIII	Skilled Nursing Facility	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)	3,232	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,232	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.	2,159	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,073	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,562	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,098,247	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,098,247	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	3,544,863	28.00
29.00	Private room charges (excluding swing-bed charges)	2,416,380	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,128,483	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.591912	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,119.21	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,051.71	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	67.50	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	39.95	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	86,252	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,011,995	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,011,995	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	622.52	71.00
72.00	Program routine service cost (line 9 x line 71)	972,376	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	972,376	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	972,376	83.00
84.00	Program inpatient ancillary services (see instructions)	589,363	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,561,739	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: 15-0075 Component CCN: 15-5373	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 4:19 pm
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,453,983		30.00
31.00	03100	INTENSIVE CARE UNIT		1,428,003		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.092484	2,358,128	218,089	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682976	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074051	2,335,332	172,934	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.206042	74,504	15,351	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.070738	4,495,444	317,999	60.00
65.00	06500	RESPIRATORY THERAPY	0.261086	1,205,247	314,673	65.00
66.00	06600	PHYSICAL THERAPY	0.227292	306,622	69,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148494	921,163	136,787	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045119	1,439,221	64,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225565	1,336,713	301,516	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174557	2,040,221	356,135	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.320021	0	0	76.01
76.03	03953	WOUND CARE	0.301939	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.397618	11,283	4,486	90.00
91.00	09100	EMERGENCY	0.132636	1,414,001	187,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380007	185,440	70,468	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,123,319	2,230,614	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)		18,123,319		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Skilled Nursing Facility | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.092484	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682976	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074051	34,945	2,588	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.206042	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.070738	283,401	20,047	60.00
65.00	06500	RESPIRATORY THERAPY	0.261086	264,962	69,178	65.00
66.00	06600	PHYSICAL THERAPY	0.227292	1,599,063	363,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148494	8,151	1,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045119	211,141	9,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225565	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174557	706,705	123,360	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.320021	0	0	76.01
76.03	03953	WOUND CARE	0.301939	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.397618	0	0	90.00
91.00	09100	EMERGENCY	0.132636	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380007	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,108,368	589,363	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,108,368		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 4:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		57,603		30.00
31.00	03100	INTENSIVE CARE UNIT		82,926		31.00
43.00	04300	NURSERY		45,462		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.092484	49,693	4,596	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682976	13,174	8,998	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074051	16,928	1,254	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.206042	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.070738	104,055	7,361	60.00
65.00	06500	RESPIRATORY THERAPY	0.261086	31,042	8,105	65.00
66.00	06600	PHYSICAL THERAPY	0.227292	4,244	965	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148494	9,139	1,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045119	22,246	1,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225565	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174557	74,838	13,063	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.320021	0	0	76.01
76.03	03953	WOUND CARE	0.301939	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.397618	429	171	90.00
91.00	09100	EMERGENCY	0.132636	16,579	2,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380007	4,522	1,718	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		346,889	50,791	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)		346,889		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/28/2018 4:19 pm
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,244,936	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)	6,052	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	1,393,447	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	59.64	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.12	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.07	31.00
32.00	Sum of lines 30 and 31	26.19	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.82	33.00
34.00	Disproportionate share adjustment (see instructions)	87,776	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Date/Time Prepared: 2/28/2018 4:19 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,271	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000040063	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	239,476	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	239,476	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	239,476		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,578,240		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)		3,578,240	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		262,092	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,840,332	59.00
60.00	Primary payer payments		6,271	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,834,061	61.00
62.00	Deductibles billed to program beneficiaries		555,968	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		12,653	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		8,224	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,653	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,286,317	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-16,934	70.93
70.94	HRR adjustment amount (see instructions)		-73,011	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2017	390,205	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,586,577	71.00
71.01	Sequestration adjustment (see instructions)		71,732	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		3,416,188	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		98,657	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		871,573	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)		1.0080897677	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)		0.9842	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2018 4:19 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,244,936	0		3,244,936	3,244,936	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	6,052	0	0	6,052	6,052	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	1,393,447	0	0	1,393,447	1,393,447	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1082	0.1082	0.1082	0.1082		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,776	0	0	87,776	87,776	11.00
11.01	Uncompensated care payments	36.00	239,476	0	0	239,476	239,476	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	3,578,240	0	0	3,578,240	3,578,240	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	3,578,240	0	0	3,578,240	3,578,240	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	262,092	0	0	262,092	262,092	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2018 4:19 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	3,840,332	3,840,332	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	260,276	0	0	260,276	260,276	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	1,816	0	0	1,816	1,816	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	262,092	0	0	262,092	262,092	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	0.101607		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				390,205	390,205	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/28/2018 4:19 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	968	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,046,410	2.00
3.00	OPPS payments	2,652,798	3.00
4.00	Outlier payment (see instructions)	20,715	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	968	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,309	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	5,309	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	5,309	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,341	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instructions)	968	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2,673,513	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	660	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	542,363	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,131,458	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,131,458	30.00
31.00	Primary payer payments	1,330	31.00
32.00	Subtotal (line 30 minus line 31)	2,130,128	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)	56,218	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	36,542	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	56,218	36.00
37.00	Subtotal (see instructions)	2,166,670	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-16	38.00
39.00	OTHER ADJUSTMENTS PS&R	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,166,686	40.00
40.01	Sequestration adjustment (see instructions)	43,334	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,087,102	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	36,250	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: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2018 4:19 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		3,416,188		2,087,102	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,416,188		2,087,102	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		98,657		36,250	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,514,845		2,123,352	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: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 4:19 pm

Title XVIII | Skilled Nursing Facility | 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		573,734		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)		573,734		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		573,734		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/28/2018 4:19 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2018 4:19 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	632,679	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	632,679	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	47,236	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	585,443	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	ROUNDING	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	585,443	15.00
15.01	Sequestration adjustment (see instructions)	11,709	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	573,734	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/28/2018 4:19 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	-278,514	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,633,018	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,336,066	0	0	0	6.00
7.00	Inventory	1,126,011	0	0	0	7.00
8.00	Prepaid expenses	285,858	0	0	0	8.00
9.00	Other current assets	33,474	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)	6,463,781	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	748,002	0	0	0	13.00
14.00	Accumulated depreciation	-469,182	0	0	0	14.00
15.00	Buildings	20,283,829	0	0	0	15.00
16.00	Accumulated depreciation	-9,611,367	0	0	0	16.00
17.00	Leasehold improvements	5,370,165	0	0	0	17.00
18.00	Accumulated depreciation	-3,402,487	0	0	0	18.00
19.00	Fixed equipment	4,045,435	0	0	0	19.00
20.00	Accumulated depreciation	-3,113,028	0	0	0	20.00
21.00	Automobiles and trucks	47,177	0	0	0	21.00
22.00	Accumulated depreciation	-30,946	0	0	0	22.00
23.00	Major movable equipment	11,780,910	0	0	0	23.00
24.00	Accumulated depreciation	-8,594,755	0	0	0	24.00
25.00	Minor equipment depreciable	2,880,503	0	0	0	25.00
26.00	Accumulated depreciation	-2,469,228	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)	21,309,928	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,114,244	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,114,244	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,887,953	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	923,669	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,248,494	0	0	0	38.00
39.00	Payroll taxes payable	156,166	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	26,510,441	0	0	0	43.00
44.00	Other current liabilities	249,141	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,087,911	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,087,911	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,800,042				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	2,800,042	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,887,953	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/28/2018 4:19 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		4,113,712		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,417,987				2.00
3.00	Total (sum of line 1 and line 2)		1,695,725		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,695,725		0		11.00
12.00	PLUG TO RE	67,037		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		67,037		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,628,688		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	PLUG TO RE		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: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2018 4:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,853,829		9,853,829	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,544,863		3,544,863	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)	13,398,692		13,398,692	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,753,651		2,753,651	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,753,651		2,753,651	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,152,343		16,152,343	17.00
18.00	Ancillary services	46,681,432	110,908,577	157,590,009	18.00
19.00	Outpatient services	3,307,744	15,026,353	18,334,097	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	66,141,519	125,934,930	192,076,449	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,376,244		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		35,376,244		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/28/2018 4:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	192,076,449	1.00
2.00	Less contractual allowances and discounts on patients' accounts	158,532,515	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,543,934	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,376,244	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,832,310	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-1,832,310	26.00
27.00	OTHER	585,677	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	585,677	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,417,987	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0075	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/28/2018 4:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	260,276	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,816	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)	12.29	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	262,092	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