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: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 2:07 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 2:07 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 IU HEALTH PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] 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	159,012	137,312	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	43,201	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	202,213	137,312	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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 10:47 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code: 47454	County: ORANGE	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	IU HEALTH PAOLI HOSPITAL	151306	99915	1	07/01/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 10:47 am

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

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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)						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)						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)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 10:47 am

		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).						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)						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)						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	

		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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 10:47 am

			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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 10:47 am

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	46,524	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
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	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 10:47 am

	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	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.	Y	11/27/2017	146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	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)	04/01/2017	06/30/2017	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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 10:47 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2018	Y	04/04/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 10:47 am

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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	N	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 10:47 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 10:47 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	10,440.00	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)		25	9,125	10,440.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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)		25	9,125	10,440.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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

	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)	149	5	435			1.00
2.00	HMO and other (see instructions)	33	229				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	84	0	84			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	85			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	233	5	604			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		6	179			13.00
14.00	Total (see instructions)	233	11	783	0.00	131.45	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	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	131.45	27.00
28.00	Observation Bed Days		14	598			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2018 10:47 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	49	8	287	1.00
2.00	HMO and other (see instructions)			11	115		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	49	8	287	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/25/2018 10:47 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.362260	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,646,265	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,257,032	6.00
7.00	Medicaid cost (line 1 times line 6)	5,527,012	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,880,747	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,880,747	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,737,416	139,635	1,877,051	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	629,396	139,635	769,031	21.00
22.00	Payments received from patients for amounts previously written off as charity care	26,213	0	26,213	22.00
23.00	Cost of charity care (line 21 minus line 22)	603,183	139,635	742,818	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)	2,955,432	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	728,809	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,121,244	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,834,188	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,056,888	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,799,706	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,680,453	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	544,027	544,027	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	808,471	808,471	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	59,613	241,876	301,489	1,324,113	1,625,602	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	586,756	7,307,919	7,894,675	-192,271	7,702,404	5.00
7.00	00700	OPERATION OF PLANT	378,055	1,158,377	1,536,432	-674,051	862,381	7.00
7.01	00701	UTILITIES	0	0	0	374,502	374,502	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,014	70,014	0	70,014	8.00
9.00	00900	HOUSEKEEPING	198,612	135,873	334,485	-69,187	265,298	9.00
10.00	01000	DIETARY	180,459	155,558	336,017	-236,596	99,421	10.00
11.00	01100	CAFETERIA	0	0	0	168,094	168,094	11.00
13.00	01300	NURSING ADMINISTRATION	544,783	257,840	802,623	-233,725	568,898	13.00
13.01	01301	HOUSE SUPERVISORS	383,700	86,936	470,636	-58,767	411,869	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-799	-799	325,018	324,219	14.00
15.00	01500	PHARMACY	209,886	1,640,633	1,850,519	-1,357,079	493,440	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,367	16,367	-4,233	12,134	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	340,995	68,217	409,212	-37,165	372,047	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,045,551	488,616	1,534,167	-459,626	1,074,541	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	39,600	18,481	58,081	57,614	115,695	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	457,693	390,328	848,021	-310,066	537,955	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,743	0	34,743	17,503	52,246	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	704,530	1,027,657	1,732,187	-594,028	1,138,159	54.00
60.00	06000	LABORATORY	87,471	952,927	1,040,398	-5,345	1,035,053	60.00
64.00	06400	INTRAVENOUS THERAPY	66,814	43,295	110,109	-23,393	86,716	64.00
65.00	06500	RESPIRATORY THERAPY	295,638	150,734	446,372	-106,710	339,662	65.00
66.00	06600	PHYSICAL THERAPY	565,673	316,151	881,824	-270,087	611,737	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	78,726	78,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,745	11,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,347,407	1,347,407	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	64,935	30,769	95,704	-14,681	81,023	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	23,386	38,321	61,707	-810	60,897	90.00
91.00	09100	EMERGENCY	1,222,463	1,504,083	2,726,546	-373,373	2,353,173	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,491,356	16,100,173	23,591,529	36,027	23,627,556	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	728	728	-717	11	190.01
190.02	19002	OUTREACH	126,189	69,199	195,388	-25,749	169,639	190.02
190.03	19003	FOUNDATION	0	3,137	3,137	0	3,137	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	6,326	6,326	-2,257	4,069	190.05
190.06	19006	OTHER PROPERTY	0	7,320	7,320	-7,304	16	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,617,545	16,186,883	23,804,428	0	23,804,428	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 10:47 am

		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	139,376	683,403	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-141,776	666,695	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-327,362	1,298,240	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,343,144	5,359,260	5.00
7.00	00700	OPERATION OF PLANT	0	862,381	7.00
7.01	00701	UTILITIES	0	374,502	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,014	8.00
9.00	00900	HOUSEKEEPING	-74	265,224	9.00
10.00	01000	DIETARY	0	99,421	10.00
11.00	01100	CAFETERIA	-49,340	118,754	11.00
13.00	01300	NURSING ADMINISTRATION	-252	568,646	13.00
13.01	01301	HOUSE SUPERVISORS	0	411,869	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	324,219	14.00
15.00	01500	PHARMACY	0	493,440	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,384	6,750	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-98,119	273,928	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-109	1,074,432	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	115,695	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,000	536,955	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,246	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,138,159	54.00
60.00	06000	LABORATORY	-413	1,034,640	60.00
64.00	06400	INTRAVENOUS THERAPY	0	86,716	64.00
65.00	06500	RESPIRATORY THERAPY	0	339,662	65.00
66.00	06600	PHYSICAL THERAPY	-13,800	597,937	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	805	1,348,212	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	81,023	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	60,897	90.00
91.00	09100	EMERGENCY	-74,832	2,278,341	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
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,915,424	20,712,132	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	11	190.01
190.02	19002	OUTREACH	0	169,639	190.02
190.03	19003	FOUNDATION	0	3,137	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,069	190.05
190.06	19006	OTHER PROPERTY	0	16	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,915,424	20,889,004	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,324,916	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
	0		0	1,324,916	
	B - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,347,407	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
	0		0	1,347,407	
	C - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	78,726	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
	0		0	78,726	
	D - CAPITAL RELATED COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	374,447	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	808,471	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	1,182,918	
	E - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,745	1.00
	0		0	11,745	
	F - LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,580	1.00
	0		0	169,580	

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	G - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00	0	36,533	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
	0		0	36,533	
	H - NON-BILLABE MED SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	328,544	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
	0		0	328,544	
	I - COO/CNO				
1.00	ADMINISTRATIVE & GENERAL	5.00	157,802	0	1.00
	0		157,802	0	
	J - UTILITIES				
1.00	UTILITIES	7.01	0	374,502	1.00
	0		0	374,502	
	L - OBSTETRICS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	11,976	5,527	1.00
2.00	NURSERY	43.00	62,007	12,914	2.00
	0		73,983	18,441	
	M - CAFETERIA				
1.00	CAFETERIA	11.00	113,392	54,702	1.00
	0		113,392	54,702	
500.00	Grand Total: Increases		345,177	4,928,014	500.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 10:47 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,636	0	1.00
2.00	OPERATION OF PLANT	7.00	0	59,395	0	2.00
3.00	HOUSEKEEPING	9.00	0	63,840	0	3.00
4.00	DIETARY	10.00	0	59,137	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	73,776	0	5.00
6.00	HOUSE SUPERVISORS	13.01	0	58,767	0	6.00
7.00	PHARMACY	15.00	0	29,039	0	7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00	0	14,181	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	261,371	0	9.00
10.00	OPERATING ROOM	50.00	0	94,034	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	133,164	0	11.00
12.00	LABORATORY	60.00	0	477	0	12.00
13.00	INTRAVENOUS THERAPY	64.00	0	13,778	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	44,862	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	106,686	0	15.00
16.00	CARDIAC REHABILITATION	76.97	0	10,992	0	16.00
17.00	CLINIC	90.00	0	810	0	17.00
18.00	EMERGENCY	91.00	0	213,758	0	18.00
19.00	OUTREACH	190.02	0	25,213	0	19.00
	0		0	1,324,916		
	B - BILLABLE DRUGS					
1.00	PHARMACY	15.00		1,338,819	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00		5,862	0	2.00
3.00	LABORATORY	60.00		2,586	0	3.00
4.00	OUTREACH	190.02		140	0	4.00
	0		0	1,347,407		
	C - BILLABLE SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	793	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	884	0	3.00
4.00	NURSERY	43.00	0	49	0	4.00
5.00	OPERATING ROOM	50.00	0	68,736	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,472	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	204	0	7.00
8.00	PHYSICAL THERAPY	66.00	0	328	0	8.00
9.00	EMERGENCY	91.00	0	5,258	0	9.00
	0		0	78,726		
	D - CAPITAL RELATED COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	116,030	9	2.00
3.00	OPERATION OF PLANT	7.00	0	239,940	0	3.00
4.00	HOUSEKEEPING	9.00	0	201	0	4.00
5.00	DIETARY	10.00	0	8,012	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,975	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,693	0	7.00
8.00	PHARMACY	15.00	0	9,328	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,230	0	9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	18,897	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	65,321	0	11.00
12.00	NURSERY	43.00	0	1,300	0	12.00
13.00	OPERATING ROOM	50.00	0	73,300	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	403,411	0	14.00
15.00	LABORATORY	60.00	0	1,563	0	15.00
16.00	INTRAVENOUS THERAPY	64.00	0	1,628	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	29,798	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	155,753	0	18.00
19.00	CARDIAC REHABILITATION	76.97	0	2,554	0	19.00
20.00	EMERGENCY	91.00	0	35,606	0	20.00
21.00	VISITING SPECIALTY CLINIC	190.01	0	717	0	21.00
22.00	OUTREACH	190.02	0	308	0	22.00
23.00	PAOLI FAMILY PRACTICE	190.05	0	2,257	0	23.00
24.00	OTHER PROPERTY	190.06	0	7,293	0	24.00
	0		0	1,182,918		
	E - IMPLANT SUPPLIES					
1.00	OPERATING ROOM	50.00	0	11,745	0	1.00
	0		0	11,745		
	F - LEASE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	169,580	10	1.00
	0		0	169,580		
	G - NON-BILLABLE DRUGS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3	0	1.00
2.00	DIETARY	10.00	0	105	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	40	0	3.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 10:47 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
4.00	NONPHYSICIAN ANESTHETISTS	19.00	0	19	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,610	0	5.00
6.00	NURSERY	43.00	0	252	0	6.00
7.00	OPERATING ROOM	50.00	0	3,690	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,715	0	8.00
9.00	LABORATORY	60.00	0	61	0	9.00
10.00	INTRAVENOUS THERAPY	64.00	0	781	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	42	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	101	0	12.00
13.00	EMERGENCY	91.00	0	8,114	0	13.00
	0		0	36,533		
	H - NON-BILLABE MED SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,822	0	1.00
2.00	OPERATION OF PLANT	7.00	0	214	0	2.00
3.00	HOUSEKEEPING	9.00	0	5,146	0	3.00
4.00	DIETARY	10.00	0	1,248	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	172	0	5.00
6.00	PHARMACY	15.00	0	16,426	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	3	0	7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,068	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	37,016	0	9.00
10.00	NURSERY	43.00	0	15,706	0	10.00
11.00	OPERATING ROOM	50.00	0	58,561	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	28,404	0	12.00
13.00	LABORATORY	60.00	0	658	0	13.00
14.00	INTRAVENOUS THERAPY	64.00	0	7,206	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	31,804	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	7,219	0	16.00
17.00	CARDIAC REHABILITATION	76.97	0	1,135	0	17.00
18.00	EMERGENCY	91.00	0	110,637	0	18.00
19.00	OUTREACH	190.02	0	88	0	19.00
20.00	OTHER PROPERTY	190.06	0	11	0	20.00
	0		0	328,544		
	I - COO/CNO					
1.00	NURSING ADMINISTRATION	13.00	157,802	0	0	1.00
	0		157,802	0		
	J - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	374,502	0	1.00
	0		0	374,502		
	L - OBSTETRICS					
1.00	ADULTS & PEDIATRICS	30.00	73,983	18,441	0	1.00
2.00		0.00	0	0	0	2.00
	0		73,983	18,441		
	M - CAFETERIA					
1.00	DIETARY	10.00	113,392	54,702	0	1.00
	0		113,392	54,702		
500.00	Grand Total: Decreases		345,177	4,928,014		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I Date/Time Prepared: 5/25/2018 10:47 am

		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	148,000	0	0	0	0	1.00
2.00	Land Improvements	438,464	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	0	0	0	3.00
4.00	Building Improvements	877,722	731,335	0	731,335	192,930	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,065,053	1,213,166	0	1,213,166	628,759	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,270,961	1,944,501	0	1,944,501	821,689	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,270,961	1,944,501	0	1,944,501	821,689	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	148,000	0	1.00
2.00	Land Improvements	438,464	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	3.00
4.00	Building Improvements	1,416,127	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,649,460	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,393,773	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,393,773	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2018 10:47 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III | Date/Time Prepared: 5/25/2018 10:47 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,744,314	0	6,744,314	0.387743	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,649,460	0	10,649,460	0.612257	0	2.00
3.00	Total (sum of lines 1-2)	17,393,774	0	17,393,774	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	516,223	167,180	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	666,695	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,182,918	167,180	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	683,403	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	666,695	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,350,098	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 10:47 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,400	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,198,217			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	1,623,888			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-141,776	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-104,295	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 10:47 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-49,340	CAFETERIA	11.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-131	NURSING ADMINISTRATION	13.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-5,384	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-1,000	OPERATING ROOM	50.00	0	33.04
33.06	MISCELLANEOUS INCOME	B	-13,800	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	805	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-435	EMERGENCY	91.00	0	33.08
33.09	UNWONTED SITUATIONS	B	-2,240	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HAF	A	-501,809	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	TO ADJUST BUDGET TO ACTUAL	A	-4,241	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ACCRUED PTO	A	-54,718	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	BENEFITS	A	-1,393,934	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	CRNA	A	-98,119	NONPHYSICIAN ANESTHETISTS	19.00	0	33.14
33.15	MARKETING	A	-895	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	MARKETING	A	-121	NURSING ADMINISTRATION	13.00	0	33.16
33.17	MARKETING	A	-109	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	RECRUITMENT	A	35,535	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	CONTRIBUTION EXPENSE	A	-2,614	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	TELEPHONE EQUIPMENT	A	-74	HOUSEKEEPING	9.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,915,424				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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2018 10:47 am

	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	HOME OFFICE ALLOCATION	141,776	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,248,569	127,279	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,482,939	5,515,110	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	103,620	0	3.01
3.02	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	33,953	33,953	3.02
3.03	10.00	DIETARY	SHARED EMPLOYEES	8,979	8,979	3.03
3.04	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	118,886	118,886	3.04
3.05	15.00	PHARMACY	SHARED EMPLOYEES	209,748	209,748	3.05
3.08	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	5,475	5,475	3.08
3.09	60.00	LABORATORY	SHARED EMPLOYEES	969,653	969,653	3.09
3.10	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	15,289	15,289	3.10
3.11	76.97	CARDIAC REHABILITATION	SHARED EMPLOYEES	6,000	6,000	3.11
3.12	90.00	CLINIC	SHARED EMPLOYEES	39,306	39,306	3.12
4.00	91.00	EMERGENCY	SIP ER ALLOCATION	2,298,030	1,008,657	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,682,223	8,058,335	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH BLOOM	0.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00	C		0.00	IUH SIP	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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2018 10:47 am

	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	141,776	9	1.00
2.00	1,121,290	0	2.00
3.00	-1,032,171	0	3.00
3.01	103,620	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
3.08	0	0	3.08
3.09	0	0	3.09
3.10	0	0	3.10
3.11	0	0	3.11
3.12	0	0	3.12
4.00	1,289,373	0	4.00
5.00	1,623,888		5.00

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

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

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

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

6.00	HOSPITAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2018 10:47 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	834,034	834,034	0	0	0	1.00
2.00	91.00	EMERGENCY	2,044,907	1,363,770	681,137	0	0	2.00
3.00	60.00	LABORATORY	413	413	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,879,354	2,198,217	681,137		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	834,034	1.00
2.00	91.00	EMERGENCY	0	0	0	1,363,770	2.00
3.00	60.00	LABORATORY	0	0	0	413	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,198,217	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	683,403	683,403				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	666,695		666,695			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,298,240	3,674	4,002	1,305,916		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,359,260	44,220	48,167	128,650	5,580,297	5.00
7.00	00700	OPERATION OF PLANT	862,381	50,545	55,057	65,323	1,033,306	7.00
7.01	00701	UTILITIES	374,502	0	0	0	374,502	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	70,014	3,488	3,800	0	77,302	8.00
9.00	00900	HOUSEKEEPING	265,224	9,384	10,221	34,318	319,147	9.00
10.00	01000	DIETARY	99,421	19,197	20,911	11,588	151,117	10.00
11.00	01100	CAFETERIA	118,754	11,686	12,729	19,593	162,762	11.00
13.00	01300	NURSING ADMINISTRATION	568,646	8,477	9,233	66,865	653,221	13.00
13.01	01301	HOUSE SUPERVISORS	411,869	0	0	66,298	478,167	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	324,219	23,837	25,964	0	374,020	14.00
15.00	01500	PHARMACY	493,440	13,593	14,806	36,266	558,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,750	14,535	15,832	0	37,117	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	273,928	0	0	58,920	332,848	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,074,432	88,544	96,447	167,874	1,427,297	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	115,695	2,907	3,166	17,556	139,324	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	536,955	70,080	76,334	79,083	762,452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,246	4,151	4,522	8,072	68,991	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,138,159	67,836	73,890	121,734	1,401,619	54.00
60.00	06000	LABORATORY	1,034,640	21,430	23,342	15,114	1,094,526	60.00
64.00	06400	INTRAVENOUS THERAPY	86,716	5,232	5,699	11,545	109,192	64.00
65.00	06500	RESPIRATORY THERAPY	339,662	3,302	3,597	51,082	397,643	65.00
66.00	06600	PHYSICAL THERAPY	597,937	65,033	70,838	97,741	831,549	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,726	0	0	0	78,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,745	0	0	0	11,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,348,212	0	0	0	1,348,212	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	81,023	8,267	9,005	11,220	109,515	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	60,897	1,105	1,203	4,041	67,246	90.00
91.00	09100	EMERGENCY	2,278,341	46,801	50,978	211,229	2,587,349	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,712,132	587,324	639,743	1,284,112	20,567,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	11	23,372	25,457	0	48,840	190.01
190.02	19002	OUTREACH	169,639	10,500	0	21,804	201,943	190.02
190.03	19003	FOUNDATION	3,137	1,372	1,495	0	6,004	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	4,069	27,906	0	0	31,975	190.05
190.06	19006	OTHER PROPERTY	16	32,929	0	0	32,945	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	20,889,004	683,403	666,695	1,305,916	20,889,004	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,580,297					5.00
7.00	00700	OPERATION OF PLANT	376,659	1,409,965				7.00
7.01	00701	UTILITIES	136,513	0	511,015			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	28,178	11,504	3,261	120,245		8.00
9.00	00900	HOUSEKEEPING	116,335	30,946	8,773	0	475,201	9.00
10.00	01000	DIETARY	55,085	63,310	17,949	0	20,252	10.00
11.00	01100	CAFETERIA	59,330	38,538	10,926	0	12,328	11.00
13.00	01300	NURSING ADMINISTRATION	238,111	27,955	7,925	0	8,942	13.00
13.01	01301	HOUSE SUPERVISORS	174,300	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	136,337	78,610	22,287	0	0	14.00
15.00	01500	PHARMACY	203,439	44,827	12,709	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,530	47,933	13,589	0	15,333	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	121,329	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	520,275	292,009	82,786	25,245	93,409	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	50,786	9,587	2,718	0	3,067	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	277,927	231,115	65,523	10,261	73,930	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,148	13,690	3,881	3,061	4,379	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	510,915	223,714	63,424	19,781	71,562	54.00
60.00	06000	LABORATORY	398,974	70,673	20,036	0	22,607	60.00
64.00	06400	INTRAVENOUS THERAPY	39,802	17,256	4,892	0	5,520	64.00
65.00	06500	RESPIRATORY THERAPY	144,948	10,890	3,088	0	3,484	65.00
66.00	06600	PHYSICAL THERAPY	303,115	7,631	60,804	7,182	68,606	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,697	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,281	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	491,448	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	39,920	27,264	7,730	0	8,721	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	24,512	3,643	1,033	0	1,165	90.00
91.00	09100	EMERGENCY	943,135	154,345	43,758	54,715	49,372	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,463,029	1,405,440	457,092	120,245	462,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	17,803	0	21,852	0	0	190.01
190.02	19002	OUTREACH	73,612	0	0	0	11,077	190.02
190.03	19003	FOUNDATION	2,189	4,525	1,283	0	1,447	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	11,655	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	12,009	0	30,788	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,580,297	1,409,965	511,015	120,245	475,201	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	307,713					10.00
11.00	01100	CAFETERIA	0	283,884				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,898	955,052			13.00
13.01	01301	HOUSE SUPERVISORS	0	13,266	0	665,733		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	611,254	14.00
15.00	01500	PHARMACY	0	10,816	1,259	877	23,706	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	4	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	5,359	0	0	5,822	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	307,713	48,001	409,817	285,671	54,988	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,934	17,494	12,194	22,670	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	18,063	106,583	74,295	93,817	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,628	32,820	22,878	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,099	1,445	1,007	40,867	54.00
60.00	06000	LABORATORY	0	34,588	0	0	1,653	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,288	20,699	14,428	10,315	64.00
65.00	06500	RESPIRATORY THERAPY	0	13,523	0	0	45,515	65.00
66.00	06600	PHYSICAL THERAPY	0	21,218	0	0	10,333	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	112,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	16,808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	2,107	10,489	7,312	1,624	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	54,328	354,446	247,071	170,323	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	307,713	279,116	955,052	665,733	611,111	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	4,768	0	0	127	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	16	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	307,713	283,884	955,052	665,733	611,254	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
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
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	855,738					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	127,506				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	12	0	0	465,370		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,614	9,955	0	0	3,558,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	156	612	0	0	260,542	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,282	14,981	0	465,370	2,196,599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,464	0	0	180,940	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,810	20,808	0	0	2,399,051	54.00
60.00	06000	LABORATORY	38	15,185	0	0	1,658,280	60.00
64.00	06400	INTRAVENOUS THERAPY	483	2,700	0	0	227,575	64.00
65.00	06500	RESPIRATORY THERAPY	26	1,721	0	0	620,838	65.00
66.00	06600	PHYSICAL THERAPY	62	4,077	0	0	1,314,577	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	815	0	0	220,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	252	0	0	33,086	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	833,237	13,992	0	0	2,686,889	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	5,018	480	0	0	220,180	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	87	0	0	97,686	90.00
91.00	09100	EMERGENCY	0	39,377	0	0	4,698,219	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	855,738	127,506	0	465,370	20,374,146	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	88,495	190.01
190.02	19002	OUTREACH	0	0	0	0	291,527	190.02
190.03	19003	FOUNDATION	0	0	0	0	15,448	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	43,630	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	75,758	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	855,738	127,506	0	465,370	20,889,004	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 10:47 am

		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
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
13.01	01301	HOUSE SUPERVISORS			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	3,558,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	260,542	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	2,196,599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	180,940	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,399,051	54.00
60.00	06000	LABORATORY	0	1,658,280	60.00
64.00	06400	INTRAVENOUS THERAPY	0	227,575	64.00
65.00	06500	RESPIRATORY THERAPY	0	620,838	65.00
66.00	06600	PHYSICAL THERAPY	0	1,314,577	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	220,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,086	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,686,889	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	220,180	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	97,686	90.00
91.00	09100	EMERGENCY	0	4,698,219	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
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	20,374,146	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	88,495	190.01
190.02	19002	OUTREACH	0	291,527	190.02
190.03	19003	FOUNDATION	0	15,448	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	43,630	190.05
190.06	19006	OTHER PROPERTY	0	75,758	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
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	20,889,004	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,674	4,002	7,676	7,676	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	44,220	48,167	92,387	756	5.00
7.00	00700	OPERATION OF PLANT	0	50,545	55,057	105,602	384	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,488	3,800	7,288	0	8.00
9.00	00900	HOUSEKEEPING	0	9,384	10,221	19,605	202	9.00
10.00	01000	DIETARY	0	19,197	20,911	40,108	68	10.00
11.00	01100	CAFETERIA	0	11,686	12,729	24,415	115	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,477	9,233	17,710	393	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	390	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,837	25,964	49,801	0	14.00
15.00	01500	PHARMACY	0	13,593	14,806	28,399	213	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,535	15,832	30,367	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	346	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	88,544	96,447	184,991	987	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,907	3,166	6,073	103	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	70,080	76,334	146,414	465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,151	4,522	8,673	47	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,836	73,890	141,726	716	54.00
60.00	06000	LABORATORY	0	21,430	23,342	44,772	89	60.00
64.00	06400	INTRAVENOUS THERAPY	0	5,232	5,699	10,931	68	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,302	3,597	6,899	300	65.00
66.00	06600	PHYSICAL THERAPY	0	65,033	70,838	135,871	575	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	8,267	9,005	17,272	66	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,105	1,203	2,308	24	90.00
91.00	09100	EMERGENCY	0	46,801	50,978	97,779	1,241	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	587,324	639,743	1,227,067	7,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	23,372	25,457	48,829	0	190.01
190.02	19002	OUTREACH	0	10,500	0	10,500	128	190.02
190.03	19003	FOUNDATION	0	1,372	1,495	2,867	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	27,906	0	27,906	0	190.05
190.06	19006	OTHER PROPERTY	0	32,929	0	32,929	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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	683,403	666,695	1,350,098	7,676	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	93,143					5.00
7.00	00700	OPERATION OF PLANT	6,287	112,273				7.00
7.01	00701	UTILITIES	2,278	0	2,278			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	470	916	15	8,689		8.00
9.00	00900	HOUSEKEEPING	1,942	2,464	39	0	24,252	9.00
10.00	01000	DIETARY	919	5,041	80	0	1,034	10.00
11.00	01100	CAFETERIA	990	3,069	49	0	629	11.00
13.00	01300	NURSING ADMINISTRATION	3,974	2,226	35	0	456	13.00
13.01	01301	HOUSE SUPERVISORS	2,909	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,276	6,260	99	0	0	14.00
15.00	01500	PHARMACY	3,396	3,570	57	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	226	3,817	61	0	783	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,025	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,684	23,252	369	1,824	4,767	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	848	763	12	0	157	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,639	18,403	292	741	3,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	420	1,090	17	221	223	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,527	17,814	283	1,429	3,652	54.00
60.00	06000	LABORATORY	6,659	5,628	89	0	1,154	60.00
64.00	06400	INTRAVENOUS THERAPY	664	1,374	22	0	282	64.00
65.00	06500	RESPIRATORY THERAPY	2,419	867	14	0	178	65.00
66.00	06600	PHYSICAL THERAPY	5,059	608	271	519	3,501	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	479	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,203	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	666	2,171	34	0	445	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	409	290	5	0	59	90.00
91.00	09100	EMERGENCY	15,746	12,290	195	3,955	2,520	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,185	111,913	2,038	8,689	23,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	297	0	97	0	0	190.01
190.02	19002	OUTREACH	1,229	0	0	0	565	190.02
190.03	19003	FOUNDATION	37	360	6	0	74	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	195	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	200	0	137	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,143	112,273	2,278	8,689	24,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	47,250					10.00
11.00	01100	CAFETERIA	0	29,267				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,948	26,742			13.00
13.01	01301	HOUSE SUPERVISORS	0	1,368	0	4,667		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	58,436	14.00
15.00	01500	PHARMACY	0	1,115	35	6	2,266	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	552	0	0	557	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,250	4,949	11,475	2,004	5,257	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	199	490	85	2,167	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,862	2,984	521	8,969	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	374	919	160	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,206	40	7	3,907	54.00
60.00	06000	LABORATORY	0	3,566	0	0	158	60.00
64.00	06400	INTRAVENOUS THERAPY	0	236	580	101	986	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,394	0	0	4,351	65.00
66.00	06600	PHYSICAL THERAPY	0	2,187	0	0	988	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	217	294	51	155	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	5,602	9,925	1,732	16,283	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,250	28,775	26,742	4,667	58,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	492	0	0	12	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	2	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	47,250	29,267	26,742	4,667	58,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
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
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	39,057					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,254				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1	0	0	3,481		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74	2,753	0		298,636	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	7	169	0		11,073	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104	4,143	0		193,310	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	681	0		12,825	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	585	5,755	0		187,647	54.00
60.00	06000	LABORATORY	2	4,200	0		66,317	60.00
64.00	06400	INTRAVENOUS THERAPY	22	747	0		16,013	64.00
65.00	06500	RESPIRATORY THERAPY	1	476	0		16,899	65.00
66.00	06600	PHYSICAL THERAPY	3	1,127	0		150,709	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	225	0		11,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70	0		1,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,029	3,870	0		50,102	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0		0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		0	75.00
75.01	07501	CARDIAC REHAB	0	0	0		0	75.01
76.97	07697	CARDIAC REHABILITATION	229	133	0		21,733	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000	CLINIC	0	24	0		3,119	90.00
91.00	09100	EMERGENCY	0	10,881	0		178,149	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	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,057	35,254	0	0	1,219,755	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		49,223	190.01
190.02	19002	OUTREACH	0	0	0		12,926	190.02
190.03	19003	FOUNDATION	0	0	0		3,344	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		28,101	190.05
190.06	19006	OTHER PROPERTY	0	0	0		33,268	190.06
191.00	19100	RESEARCH	0	0	0		0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
193.00	19300	NONPAID WORKERS	0	0	0		0	193.00
200.00		Cross Foot Adjustments				3,481	3,481	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,057	35,254	0	3,481	1,350,098	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 10:47 am

		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
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
13.01	01301	HOUSE SUPERVISORS			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	298,636	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	11,073	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	193,310	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,825	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,647	54.00
60.00	06000	LABORATORY	0	66,317	60.00
64.00	06400	INTRAVENOUS THERAPY	0	16,013	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,899	65.00
66.00	06600	PHYSICAL THERAPY	0	150,709	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,102	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	21,733	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	3,119	90.00
91.00	09100	EMERGENCY	0	178,149	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
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,219,755	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	49,223	190.01
190.02	19002	OUTREACH	0	12,926	190.02
190.03	19003	FOUNDATION	0	3,344	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	28,101	190.05
190.06	19006	OTHER PROPERTY	0	33,268	190.06
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		Cross Foot Adjustments	0	3,481	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,350,098	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	58,774					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		52,639				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	316	316	7,557,932			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,803	3,803	744,558	-5,580,297	15,308,707	5.00
7.00	00700	OPERATION OF PLANT	4,347	4,347	378,055	0	1,033,306	7.00
7.01	00701	UTILITIES	0	0	0	0	374,502	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	77,302	8.00
9.00	00900	HOUSEKEEPING	807	807	198,612	0	319,147	9.00
10.00	01000	DIETARY	1,651	1,651	67,067	0	151,117	10.00
11.00	01100	CAFETERIA	1,005	1,005	113,392	0	162,762	11.00
13.00	01300	NURSING ADMINISTRATION	729	729	386,981	0	653,221	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	383,700	0	478,167	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,050	2,050	0	0	374,020	14.00
15.00	01500	PHARMACY	1,169	1,169	209,886	0	558,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,250	1,250	0	0	37,117	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	340,995	0	332,848	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,615	7,615	971,568	0	1,427,297	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	101,607	0	139,324	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	457,693	0	762,452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	357	357	46,719	0	68,991	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,834	5,834	704,530	0	1,401,619	54.00
60.00	06000	LABORATORY	1,843	1,843	87,471	0	1,094,526	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	66,814	0	109,192	64.00
65.00	06500	RESPIRATORY THERAPY	284	284	295,638	0	397,643	65.00
66.00	06600	PHYSICAL THERAPY	5,593	5,593	565,673	0	831,549	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	78,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,348,212	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	711	711	64,935	0	109,515	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	95	95	23,386	0	67,246	90.00
91.00	09100	EMERGENCY	4,025	4,025	1,222,463	0	2,587,349	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,511	50,511	7,431,743	-5,580,297	14,987,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	2,010	2,010	0	0	48,840	190.01
190.02	19002	OUTREACH	903	0	126,189	0	201,943	190.02
190.03	19003	FOUNDATION	118	118	0	0	6,004	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	2,400	0	0	0	31,975	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	32,945	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	683,403	666,695	1,305,916		5,580,297	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.627641	12.665419	0.172787		0.364518	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,676		93,143	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

		CAPITAL RELATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001016		0.006084	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	36,769					7.00
7.01	00701	UTILITIES	0	47,005				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	12,808			8.00
9.00	00900	HOUSEKEEPING	807	807	0	38,740		9.00
10.00	01000	DIETARY	1,651	1,651	0	1,651	3,774	10.00
11.00	01100	CAFETERIA	1,005	1,005	0	1,005	0	11.00
13.00	01300	NURSING ADMINISTRATION	729	729	0	729	0	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,050	2,050	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,250	1,250	0	1,250	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,615	7,615	2,689	7,615	3,774	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	0	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	1,093	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	357	357	326	357	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,834	5,834	2,107	5,834	0	54.00
60.00	06000	LABORATORY	1,843	1,843	0	1,843	0	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	0	450	0	64.00
65.00	06500	RESPIRATORY THERAPY	284	284	0	284	0	65.00
66.00	06600	PHYSICAL THERAPY	199	5,593	765	5,593	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	711	711	0	711	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	95	95	0	95	0	90.00
91.00	09100	EMERGENCY	4,025	4,025	5,828	4,025	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,651	42,045	12,808	37,719	3,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	2,010	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	903	0	190.02
190.03	19003	FOUNDATION	118	118	0	118	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,409,965	511,015	120,245	475,201	307,713	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.346569	10.871503	9.388273	12.266417	81.534976	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	112,273	2,278	8,689	24,252	47,250	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.053469	0.048463	0.678404	0.626020	12.519873	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1306

Period: From 01/01/2017 To 12/31/2017

Worksheet B-1

Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	220,376					11.00
13.00	01300	NURSING ADMINISTRATION	14,670	81,945				13.00
13.01	01301	HOUSE SUPERVISORS	10,298	0	81,945			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	427,117		14.00
15.00	01500	PHARMACY	8,396	108	108	16,565	1,383,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,160	0	0	4,068	19	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,263	35,163	35,163	38,423	2,610	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,501	1,501	1,501	15,841	252	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,022	9,145	9,145	65,555	3,690	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,816	2,816	2,816	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,142	124	124	28,556	20,714	54.00
60.00	06000	LABORATORY	26,850	0	0	1,155	61	60.00
64.00	06400	INTRAVENOUS THERAPY	1,776	1,776	1,776	7,208	781	64.00
65.00	06500	RESPIRATORY THERAPY	10,498	0	0	31,804	42	65.00
66.00	06600	PHYSICAL THERAPY	16,471	0	0	7,220	101	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	78,726	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,745	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,347,407	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1,636	900	900	1,135	8,114	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	42,176	30,412	30,412	119,013	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	216,675	81,945	81,945	427,017	1,383,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	3,701	0	0	89	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	11	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	283,884	955,052	665,733	611,254	855,738	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.288180	11.654793	8.124144	1.431116	0.618401	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,267	26,742	4,667	58,436	39,057	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.132805	0.326341	0.056953	0.136815	0.028225	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	14.00	15.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	UTILITIES					7.01
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
13.01	01301	HOUSE SUPERVISORS					13.01
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,241,746				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,391,154	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	270,160	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,608,387	0	100		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,086,904	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,178,544	0	0		54.00
60.00	06000	LABORATORY	6,698,107	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	1,191,132	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	759,295	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,798,232	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,580	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,010	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,172,246	0	0		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	CARDIAC REHAB	0	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	211,558	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	38,329	0	0		90.00
91.00	09100	EMERGENCY	17,367,108	0	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		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,241,746	0	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		190.01
190.02	19002	OUTREACH	0	0	0		190.02
190.03	19003	FOUNDATION	0	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		190.05
190.06	19006	OTHER PROPERTY	0	0	0		190.06
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	127,506	0	465,370		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002267	0.000000	4,653.700000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	35,254	0	3,481		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000627	0.000000	34.810000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 10:47 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		16.00	17.00	19.00		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | 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	3,558,780		3,558,780	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	260,542		260,542	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,196,599		2,196,599	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,940		180,940	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,399,051		2,399,051	0	0	54.00
60.00	06000	LABORATORY	1,658,280		1,658,280	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	227,575		227,575	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	620,838	0	620,838	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,314,577	0	1,314,577	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220,904		220,904	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,086		33,086	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,686,889		2,686,889	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	CARDIAC REHAB	0		0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	220,180		220,180	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	97,686		97,686	0	0	90.00
91.00	09100	EMERGENCY	4,698,219		4,698,219	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,898,184		1,898,184		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,272,330	0	22,272,330	0	0	200.00
201.00		Less Observation Beds	1,898,184		1,898,184		0	201.00
202.00		Total (see instructions)	20,374,146	0	20,374,146	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,074,499		1,074,499			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	270,160		270,160			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	772,768	5,835,619	6,608,387	0.332396	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	730,858	356,046	1,086,904	0.166473	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,433	9,099,111	9,178,544	0.261376	0.000000	54.00
60.00	06000	LABORATORY	251,553	6,446,554	6,698,107	0.247574	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	4,302	1,186,830	1,191,132	0.191058	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	97,551	661,744	759,295	0.817651	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	73,950	1,724,282	1,798,232	0.731039	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,476	323,104	359,580	0.614339	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	111,010	111,010	0.298045	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,485	5,569,761	6,172,246	0.435318	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0.000000	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	56,141	155,417	211,558	1.040755	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	38,329	38,329	2.548619	0.000000	90.00
91.00	09100	EMERGENCY	199,121	17,167,987	17,367,108	0.270524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	59,330	3,257,325	3,316,655	0.572319	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,308,627	51,933,119	56,241,746			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,308,627	51,933,119	56,241,746			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	07501	CARDIAC REHAB	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
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
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,558,780		3,558,780	0	3,558,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	260,542		260,542	0	260,542	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,196,599		2,196,599	0	2,196,599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,940		180,940	0	180,940	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,399,051		2,399,051	0	2,399,051	54.00
60.00	06000	LABORATORY	1,658,280		1,658,280	0	1,658,280	60.00
64.00	06400	INTRAVENOUS THERAPY	227,575		227,575	0	227,575	64.00
65.00	06500	RESPIRATORY THERAPY	620,838	0	620,838	0	620,838	65.00
66.00	06600	PHYSICAL THERAPY	1,314,577	0	1,314,577	0	1,314,577	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220,904		220,904	0	220,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,086		33,086	0	33,086	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,686,889		2,686,889	0	2,686,889	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	CARDIAC REHAB	0		0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	220,180		220,180	0	220,180	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	97,686		97,686	0	97,686	90.00
91.00	09100	EMERGENCY	4,698,219		4,698,219	0	4,698,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,898,184		1,898,184		1,898,184	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,272,330	0	22,272,330	0	22,272,330	200.00
201.00		Less Observation Beds	1,898,184		1,898,184		1,898,184	201.00
202.00		Total (see instructions)	20,374,146	0	20,374,146	0	20,374,146	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,074,499		1,074,499			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	270,160		270,160			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	772,768	5,835,619	6,608,387	0.332396	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	730,858	356,046	1,086,904	0.166473	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,433	9,099,111	9,178,544	0.261376	0.000000	54.00
60.00	06000	LABORATORY	251,553	6,446,554	6,698,107	0.247574	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	4,302	1,186,830	1,191,132	0.191058	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	97,551	661,744	759,295	0.817651	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	73,950	1,724,282	1,798,232	0.731039	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,476	323,104	359,580	0.614339	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	111,010	111,010	0.298045	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,485	5,569,761	6,172,246	0.435318	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0.000000	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	56,141	155,417	211,558	1.040755	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	38,329	38,329	2.548619	0.000000	90.00
91.00	09100	EMERGENCY	199,121	17,167,987	17,367,108	0.270524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	59,330	3,257,325	3,316,655	0.572319	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,308,627	51,933,119	56,241,746			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,308,627	51,933,119	56,241,746			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.332396	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	54.00
60.00	06000	LABORATORY	0.247574	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	07501	CARDIAC REHAB	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	2.548619	90.00
91.00	09100	EMERGENCY	0.270524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,196,599	193,310	2,003,289	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,940	12,825	168,115	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,399,051	187,647	2,211,404	0	0	54.00
60.00	06000	LABORATORY	1,658,280	66,317	1,591,963	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	227,575	16,013	211,562	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	620,838	16,899	603,939	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,314,577	150,709	1,163,868	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220,904	11,475	209,429	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,086	1,748	31,338	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,686,889	50,102	2,636,787	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	220,180	21,733	198,447	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	97,686	3,119	94,567	0	0	90.00
91.00	09100	EMERGENCY	4,698,219	178,149	4,520,070	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,898,184	159,286	1,738,898	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,453,008	1,069,332	17,383,676	0	0	200.00
201.00		Less Observation Beds	1,898,184	159,286	1,738,898	0	0	201.00
202.00		Total (line 200 minus line 201)	16,554,824	910,046	15,644,778	0	0	202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,196,599	6,608,387	0.332396	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,940	1,086,904	0.166473	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,399,051	9,178,544	0.261376	54.00
60.00	06000	LABORATORY	1,658,280	6,698,107	0.247574	60.00
64.00	06400	INTRAVENOUS THERAPY	227,575	1,191,132	0.191058	64.00
65.00	06500	RESPIRATORY THERAPY	620,838	759,295	0.817651	65.00
66.00	06600	PHYSICAL THERAPY	1,314,577	1,798,232	0.731039	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220,904	359,580	0.614339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,086	111,010	0.298045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,686,889	6,172,246	0.435318	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	220,180	211,558	1.040755	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000	CLINIC	97,686	38,329	2.548619	90.00
91.00	09100	EMERGENCY	4,698,219	17,367,108	0.270524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,898,184	3,316,655	0.572319	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,453,008	54,897,087		200.00
201.00		Less Observation Beds	1,898,184	0		201.00
202.00		Total (line 200 minus line 201)	16,554,824	54,897,087		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		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	193,310	6,608,387	0.029252	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,825	1,086,904	0.011800	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,647	9,178,544	0.020444	28,246	577	54.00
60.00	06000	LABORATORY	66,317	6,698,107	0.009901	60,357	598	60.00
64.00	06400	INTRAVENOUS THERAPY	16,013	1,191,132	0.013444	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,899	759,295	0.022256	56,260	1,252	65.00
66.00	06600	PHYSICAL THERAPY	150,709	1,798,232	0.083810	13,241	1,110	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,475	359,580	0.031912	960	31	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,748	111,010	0.015746	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,102	6,172,246	0.008117	159,238	1,293	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	21,733	211,558	0.102728	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	3,119	38,329	0.081374	0	0	90.00
91.00	09100	EMERGENCY	178,149	17,367,108	0.010258	87,257	895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	159,286	3,316,655	0.048026	29,536	1,418	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,069,332	54,897,087		435,095	7,174	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		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	465,370	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	465,370	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		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	465,370	0	6,608,387	0.070421	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,086,904	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,178,544	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,698,107	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,191,132	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	759,295	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,798,232	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	359,580	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	111,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,172,246	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	211,558	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	38,329	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	17,367,108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,316,655	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	465,370	0	54,897,087		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,246	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	60,357	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	56,260	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	13,241	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	960	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	159,238	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	87,257	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	29,536	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		435,095	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | 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	0.332396	0	1,761,001	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	0	2,663,997	0	0	54.00
60.00	06000	LABORATORY	0.247574	0	1,989,677	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	0	378,136	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	0	198,791	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	0	587,512	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	0	67,539	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	0	28,376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	0	2,419,568	2,680	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	0	73,660	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.548619	0	13,750	0	0	90.00
91.00	09100	EMERGENCY	0.270524	0	4,535,951	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	0	1,435,458	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	16,153,416	2,680	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	16,153,416	2,680	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	585,350	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	696,305	0	54.00
60.00	06000	LABORATORY	492,592	0	60.00
64.00	06400	INTRAVENOUS THERAPY	72,246	0	64.00
65.00	06500	RESPIRATORY THERAPY	162,542	0	65.00
66.00	06600	PHYSICAL THERAPY	429,494	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,492	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,457	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,053,282	1,167	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	76,662	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	35,044	0	90.00
91.00	09100	EMERGENCY	1,227,084	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	821,540	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,702,090	1,167	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,702,090	1,167	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V

Component CCN: 15-Z306 | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Swing Beds - SNF | 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	0.332396	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	0	0	0	0	54.00
60.00	06000	LABORATORY	0.247574	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.548619	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.270524	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	298,636	23,481	275,155	1,033	266.36	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	11,073		11,073	179	61.86	43.00
200.00	Total (lines 30 through 199)	309,709		286,228	1,212		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	5	1,332	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	6	371	43.00
200.00	Total (lines 30 through 199)	11	1,703	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,310	6,608,387	0.029252	42,491	1,243	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,825	1,086,904	0.011800	19,547	231	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,647	9,178,544	0.020444	1,115	23	54.00
60.00	06000	LABORATORY	66,317	6,698,107	0.009901	11,416	113	60.00
64.00	06400	INTRAVENOUS THERAPY	16,013	1,191,132	0.013444	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,899	759,295	0.022256	179	4	65.00
66.00	06600	PHYSICAL THERAPY	150,709	1,798,232	0.083810	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,475	359,580	0.031912	2,454	78	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,748	111,010	0.015746	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,102	6,172,246	0.008117	9,333	76	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	21,733	211,558	0.102728	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	3,119	38,329	0.081374	0	0	90.00
91.00	09100	EMERGENCY	178,149	17,367,108	0.010258	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	159,286	3,316,655	0.048026	1,448	70	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,069,332	54,897,087		87,983	1,838	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	1,033	0.00	5	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	179	0.00	6	43.00
200.00		Total (lines 30 through 199)		0	1,212		11	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

Period: From 01/01/2017 To 12/31/2017

Worksheet D Part IV

Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	465,370	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	465,370	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	465,370	0	6,608,387	0.070421	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,086,904	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,178,544	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,698,107	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,191,132	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	759,295	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,798,232	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	359,580	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	111,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,172,246	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	CARDIAC REHAB	0	0	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	211,558	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	38,329	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	17,367,108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,316,655	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	465,370	0	54,897,087		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306

Period: From 01/01/2017 To 12/31/2017

Worksheet D Part IV

Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	42,491	2,992	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	19,547	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,115	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	11,416	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	179	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,454	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	9,333	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
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	1,448	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		87,983	2,992	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.332396	0	25,683	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	0	28,751	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	0	152,872	0	0	54.00
60.00	06000	LABORATORY	0.247574	0	160,508	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	0	6,679	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	0	11,934	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	0	25,892	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	0	6,228	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	0	73,184	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.548619	0	99	0	0	90.00
91.00	09100	EMERGENCY	0.270524	0	472,873	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	0	84,708	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	1,049,411	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	1,049,411	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	8,537	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,786	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,957	0	54.00
60.00	06000	LABORATORY	39,738	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,276	0	64.00
65.00	06500	RESPIRATORY THERAPY	9,758	0	65.00
66.00	06600	PHYSICAL THERAPY	18,928	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,826	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,858	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	CARDIAC REHAB	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	252	0	90.00
91.00	09100	EMERGENCY	127,923	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	48,480	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	335,319	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	335,319	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 10:47 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,202	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,033	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	435	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	84	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	85	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)	149	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)	84	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,558,780	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)	13,177	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)	279,811	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,278,969	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,278,969	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)	3,174.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	472,959	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)	472,959	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	188,425	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	661,384	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	266,634	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)	266,634	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	598	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,174.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,898,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	298,636	3,558,780	0.083915	1,898,184	159,286	90.00
91.00	Nursing School cost	0	3,558,780	0.000000	1,898,184	0	91.00
92.00	Allied health cost	0	3,558,780	0.000000	1,898,184	0	92.00
93.00	All other Medical Education	0	3,558,780	0.000000	1,898,184	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,202	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,033	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	435	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	84	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	85	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)	5	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)	179	15.00
16.00	Nursery days (title V or XIX only)	6	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,558,780	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)	13,177	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)	279,811	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,278,969	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,278,969	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)	3,174.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,871	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)	15,871	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	260,542	179	1,455.54	6	8,733	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	27,041	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	51,645	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,703	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,830	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	6,533	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	45,112	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	598	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,174.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,898,184	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 10:47 am
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	298,636	3,558,780	0.083915	1,898,184	159,286	90.00
91.00	Nursing School cost	0	3,558,780	0.000000	1,898,184	0	91.00
92.00	Allied health cost	0	3,558,780	0.000000	1,898,184	0	92.00
93.00	All other Medical Education	0	3,558,780	0.000000	1,898,184	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | 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		312,621		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	0.332396	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	28,246	7,383	54.00
60.00	06000	LABORATORY	0.247574	60,357	14,943	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	56,260	46,001	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	13,241	9,680	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	960	590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	159,238	69,319	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.548619	0	0	90.00
91.00	09100	EMERGENCY	0.270524	87,257	23,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	29,536	16,904	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)		435,095	188,425	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)		435,095		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332396	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	563	147	54.00
60.00	06000	LABORATORY	0.247574	5,794	1,434	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	3,278	2,680	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	36,048	26,352	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	31,123	13,548	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.548619	0	0	90.00
91.00	09100	EMERGENCY	0.270524	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	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)		76,806	44,161	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)		76,806		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 10:47 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,389		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		9,759		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332396	42,491	14,124	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166473	19,547	3,254	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261376	1,115	291	54.00
60.00	06000	LABORATORY	0.247574	11,416	2,826	60.00
64.00	06400	INTRAVENOUS THERAPY	0.191058	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.817651	179	146	65.00
66.00	06600	PHYSICAL THERAPY	0.731039	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.614339	2,454	1,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298045	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435318	9,333	4,063	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	CARDIAC REHAB	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1.040755	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.548619	0	0	90.00
91.00	09100	EMERGENCY	0.270524	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.572319	1,448	829	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)		87,983	27,041	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)		87,983		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part B Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,703,257	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	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)	5,703,257	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,760,290	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	39,869	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,930,845	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)	2,789,576	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)	2,789,576	30.00
31.00	Primary payer payments	874	31.00
32.00	Subtotal (line 30 minus line 31)	2,788,702	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,113,489	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	723,768	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,070,606	36.00
37.00	Subtotal (see instructions)	3,512,470	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)	3,512,470	40.00
40.01	Sequestration adjustment (see instructions)	70,249	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,304,909	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	137,312	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	135,686	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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		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		446,400		3,304,909	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)		446,400		3,304,909	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		159,012		137,312	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		605,412		3,442,221	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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 10:47 am

Component CCN: 15-Z306

Title XVIII | Swing Beds - SNF | Cost

		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		263,779		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)		263,779		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		43,201		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		306,980		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: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/25/2018 10:47 am
	Title XVIII	Hospital	Cost

		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 - SWING BEDS

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	269,300	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	44,603	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	84	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	313,903	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	313,903	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	313,903	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	658	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	313,245	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	313,245	0	19.00
19.01	Sequestration adjustment (see instructions)	6,265	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	263,779	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	43,201	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	7,416	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part V Date/Time Prepared: 5/25/2018 10:47 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	661,384	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	661,384	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	667,998	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	667,998	19.00
20.00	Deductibles (exclude professional component)	55,272	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	612,726	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	612,726	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,755	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,041	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,755	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	617,767	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	617,767	30.00
30.01	Sequestration adjustment (see instructions)	12,355	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	446,400	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	159,012	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	15,769	34.00

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

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/25/2018 10:47 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	24,533,770	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	2,374,801	0	0	0	4.00
5.00	Other receivable	-3,185,384	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	464,321	0	0	0	7.00
8.00	Prepaid expenses	121,285	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,308,793	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	148,000	0	0	0	12.00
13.00	Land improvements	438,464	0	0	0	13.00
14.00	Accumulated depreciation	-329,979	0	0	0	14.00
15.00	Buildings	6,077,459	0	0	0	15.00
16.00	Accumulated depreciation	-3,152,066	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-218,723	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	16,632	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,597,849	0	0	0	23.00
24.00	Accumulated depreciation	-6,480,691	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,888,547	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,059,882	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	7,172,828	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,232,710	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,430,050	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,107,651	0	0	0	37.00
38.00	Salaries, wages, and fees payable	814,990	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,957,674	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,880,315	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	29,591	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,591	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,909,906	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	35,520,144				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)	35,520,144	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,430,050	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/25/2018 10:47 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,730,544		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,017,804				2.00
3.00	Total (sum of line 1 and line 2)		41,748,348		0		3.00
4.00	DONATED PP&E	43,202		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)		43,202		0		10.00
11.00	Subtotal (line 3 plus line 10)		41,791,550		0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	6,271,406		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)		6,271,406		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35,520,144		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	DONATED PP&E		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	INTERCOMPANY CAPITAL TRANSFER		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: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2018 10:47 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,344,660		1,344,660	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,344,660		1,344,660	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,344,660		1,344,660	17.00
18.00	Ancillary services	2,705,518	31,469,477	34,174,995	18.00
19.00	Outpatient services	258,451	20,463,641	20,722,092	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		0	0	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 NRCC	0	68,596	68,596	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,308,629	52,001,714	56,310,343	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,804,428		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)		23,804,428		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/25/2018 10:47 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,310,343	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,691,983	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,618,360	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,804,428	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-186,068	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	MISCELLANEOUS INCOME	1,203,872	24.00
25.00	Total other income (sum of lines 6-24)	1,203,872	25.00
26.00	Total (line 5 plus line 25)	1,017,804	26.00
27.00	LAG REVENUE AND NONLAB SUPPLIES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,017,804	29.00