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: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 3:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 3:58 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 TIPTON HOSPITAL (15-1311) 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)

CHIEF FINANCIAL OFFICER
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	228,084	291,643	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	415,919	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	644,003	291,643	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 8:41 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	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 TIPTON HOSPITAL	151311	99915	1	11/12/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH TIPTON HOSPITAL	15Z311	29020		11/12/2005	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:41 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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 8:41 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:41 am

		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

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		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.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	Y	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 8:41 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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	56,568	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:41 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: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	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)	Y	16	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 8:41 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	02/22/2018	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 8:41 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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	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: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 8:41 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 OF GOVERNMENT PROGRAMS		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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2018 8:41 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	52,968.00	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	52,968.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	52,968.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 8:41 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,430	7	2,207			1.00
2.00	HMO and other (see instructions)	280	80				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	586	0	586			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	115			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,016	7	2,908			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)	2,016	7	2,908	0.00	165.50	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	165.50	27.00
28.00	Observation Bed Days		1	745			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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 8:41 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	411	4	786	1.00
2.00	HMO and other (see instructions)			81	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	411	4	786	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/29/2018 8:41 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)	0.295775	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	416,694	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,955,322	6.00
7.00	Medicaid cost (line 1 times line 6)	3,240,310	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,823,616	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)	2,823,616	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)	1,754,834	90,813	1,845,647	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	519,036	90,813	609,849	21.00
22.00	Payments received from patients for amounts previously written off as charity care	39,640	0	39,640	22.00
23.00	Cost of charity care (line 21 minus line 22)	479,396	90,813	570,209	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)	3,027,626	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	501,269	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	771,183	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,256,443	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	937,313	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,507,522	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,331,138	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 8:41 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		1,475,730	1,475,730	-880,546	595,184	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		782,994	782,994	0	782,994	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	928,632	928,632	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	49,271	2,554,919	2,604,190	-30	2,604,160	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	895,783	6,557,652	7,453,435	-150,831	7,302,604	5.00
7.00	00700	OPERATION OF PLANT	728,102	4,210,659	4,938,761	4,139	4,942,900	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	48,713	57,263	105,976	0	105,976	8.00
9.00	00900	HOUSEKEEPING	295,292	105,707	400,999	-25,626	375,373	9.00
10.00	01000	DIETARY	423,950	297,857	721,807	-484,584	237,223	10.00
11.00	01100	CAFETERIA	0	0	0	484,631	484,631	11.00
13.00	01300	NURSING ADMINISTRATION	429,982	17,925	447,907	147,202	595,109	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,077	10,077	870,448	880,525	14.00
15.00	01500	PHARMACY	572,770	2,174,595	2,747,365	-1,713,886	1,033,479	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,053,985	566,939	2,620,924	-261,069	2,359,855	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,064,435	2,338,298	3,402,733	-1,929,249	1,473,484	50.00
53.00	05300	ANESTHESIOLOGY	180,202	311,298	491,500	-9,161	482,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,074,889	309,630	1,384,519	-84,029	1,300,490	54.00
60.00	06000	LABORATORY	1,390	1,174,503	1,175,893	-10,425	1,165,468	60.00
65.00	06500	RESPIRATORY THERAPY	356,018	169,908	525,926	-23,803	502,123	65.00
66.00	06600	PHYSICAL THERAPY	627,645	73,083	700,728	-50,727	650,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,248	2,809	153,057	27,940	180,997	67.00
69.00	06900	ELECTROCARDIOLOGY	415,931	53,106	469,037	-26,756	442,281	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	248,495	248,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,273,960	1,273,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,843,685	1,843,685	73.00
73.01	03480	ONCOLOGY	177,541	17,494	195,035	-12,745	182,290	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	80,889	9,636	90,525	-818	89,707	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,148,010	1,521,993	2,670,003	-83,400	2,586,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,775,046	24,794,075	35,569,121	81,447	35,650,568	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	53,295	53,295	-824	52,471	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	129,673	72,290	201,963	-65,067	136,896	192.00
192.01	19201	OCCUPATIONAL MEDICINE	34,406	49,647	84,053	-15,556	68,497	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	10,939,125	24,969,307	35,908,432	0	35,908,432	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 8:41 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	769,125	1,364,309		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	-180,074	602,920		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	146,250	1,074,882		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-268,424	2,335,736		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,609,214	5,693,390		5.00
7.00	00700	OPERATION OF PLANT	-4,941	4,937,959		7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,976		8.00
9.00	00900	HOUSEKEEPING	-5,295	370,078		9.00
10.00	01000	DIETARY	0	237,223		10.00
11.00	01100	CAFETERIA	-115,691	368,940		11.00
13.00	01300	NURSING ADMINISTRATION	-1,060	594,049		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	880,525		14.00
15.00	01500	PHARMACY	-421,817	611,662		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-270,688	2,089,167		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-378,635	1,094,849		50.00
53.00	05300	ANESTHESIOLOGY	-430,829	51,510		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-121,753	1,178,737		54.00
60.00	06000	LABORATORY	0	1,165,468		60.00
65.00	06500	RESPIRATORY THERAPY	-3,616	498,507		65.00
66.00	06600	PHYSICAL THERAPY	-6,328	643,673		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	180,997		67.00
69.00	06900	ELECTROCARDIOLOGY	-21,248	421,033		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	248,495		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,273,960		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,843,685		73.00
73.01	03480	ONCOLOGY	0	182,290		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	89,707		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-929,378	1,657,225		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,853,616	31,796,952		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	52,471		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	136,896		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	68,497		192.01
192.02	19202	VACANT SPACE	0	0		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,853,616	32,054,816		200.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 8:41 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	284,501	199,915		1.00
	TOTALS		284,501	199,915		
	B - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	870,502		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	248,495		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,273,960		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	TOTALS		0	2,392,957		
	C - DRUGS					
1.00	CAFETERIA	11.00	0	215		1.00
2.00	PHARMACY	15.00	0	69,824		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,843,685		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
	TOTALS		0	1,913,724		
	D - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	928,632		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
	TOTALS		0	928,632		
	E - ORTHOPEDIC CLERICAL STAFF					
1.00	OCCUPATIONAL THERAPY	67.00	27,940	0		1.00
	TOTALS		27,940	0		
	F - VP OF NURSING					
1.00	NURSING ADMINISTRATION	13.00	147,203	0		1.00
	TOTALS		147,203	0		
	G - SURGERY ON-CALL					
1.00	OPERATING ROOM	50.00	0	129,985		1.00
	TOTALS		0	129,985		
	H - OVERHEAD IN NRCC					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,266		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,108		2.00
3.00	OPERATION OF PLANT	7.00	0	13,885		3.00
	TOTALS		0	59,259		
500.00	Grand Total: Increases		459,644	5,624,472		500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 8:41 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	284,501	199,915	0		1.00
	TOTALS		284,501	199,915			
	B - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	186	0		2.00
3.00	OPERATION OF PLANT	7.00	0	9,746	0		3.00
4.00	HOUSEKEEPING	9.00	0	25,626	0		4.00
5.00	DIETARY	10.00	0	168	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	1	0		6.00
7.00	PHARMACY	15.00	0	19,875	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	114,653	0		8.00
9.00	OPERATING ROOM	50.00	0	2,042,469	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	770	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,924	0		11.00
12.00	LABORATORY	60.00	0	10,425	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	23,596	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	22,585	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	17,768	0		15.00
16.00	ONCOLOGY	73.01	0	10,622	0		16.00
17.00	CARDIAC REHABILITATION	76.97	0	776	0		17.00
18.00	EMERGENCY	91.00	0	61,863	0		18.00
19.00	MARKETING/PUBLIC RELATIONS	190.01	0	824	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,770	0		20.00
21.00	OCCUPATIONAL MEDICINE	192.01	0	3,280	0		21.00
	TOTALS		0	2,392,957			
	C - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,500	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	54	0		2.00
3.00	PHARMACY	15.00	0	1,760,065	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	12,906	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,525	0		5.00
6.00	OPERATING ROOM	50.00	0	16,765	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	8,391	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,105	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	207	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	202	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	8,988	0		11.00
12.00	ONCOLOGY	73.01	0	2,123	0		12.00
13.00	CARDIAC REHABILITATION	76.97	0	42	0		13.00
14.00	EMERGENCY	91.00	0	21,537	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38	0		15.00
16.00	OCCUPATIONAL MEDICINE	192.01	0	12,276	0		16.00
	TOTALS		0	1,913,724			
	D - EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	922,959	9		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,853	12		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	50	0		3.00
4.00	PHARMACY	15.00	0	3,770	0		4.00
	TOTALS		0	928,632			
	E - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	27,940	0	0		1.00
	TOTALS		27,940	0			
	F - VP OF NURSING						
1.00	ADMINISTRATIVE & GENERAL	5.00	147,203	0	0		1.00
	TOTALS		147,203	0			
	G - SURGERY ON-CALL						
1.00	ADULTS & PEDIATRICS	30.00	0	129,985	0		1.00
	TOTALS		0	129,985			
	H - OVERHEAD IN NRCC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	59,259	10		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	59,259			
500.00	Grand Total: Decreases		459,644	5,624,472			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2018 8:41 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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,098,521	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,536,337	221,890	0	221,890	577,825	6.00
7.00	HIT designated Assets	969,306	0	0	0	4,943	7.00
8.00	Subtotal (sum of lines 1-7)	13,604,164	221,890	0	221,890	582,768	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,604,164	221,890	0	221,890	582,768	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	2,098,521	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,180,402	0	6.00
7.00	HIT designated Assets	964,363	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,243,286	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	13,243,286	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/29/2018 8:41 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	1,029,648	0	0	51,417	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	782,994	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,029,648	0	782,994	51,417	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	394,665	1,475,730	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	782,994	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	394,665	2,258,724	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2018 8:41 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,243,285	0	13,243,285	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	13,243,285	0	13,243,285	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	920,834	-754	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,074,882	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,995,716	-754	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	49,564	0	394,665	1,364,309	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	602,920	0	0	0	602,920	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,074,882	2.00
3.00	Total (sum of lines 1-2)	602,920	49,564	0	394,665	3,042,111	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 8:41 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-180,074	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-1,953,263			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	1,006,026			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	B	-412,928	PHARMACY	15.00	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	A	855,396	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	135,398	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 8:41 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	
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	-62,067	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-6,016	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-22,020	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	INVESTMENT FEES	A	8,762	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-150	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-5,295	HOUSEKEEPING	9.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-115,691	CAFETERIA	11.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-1,060	NURSING ADMINISTRATION	13.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-627	ANESTHESIOLOGY	53.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-90	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-448	RESPIRATORY THERAPY	65.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-6,149	PHYSICAL THERAPY	66.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-21,248	ELECTROCARDIOLOGY	69.00	0	33.11
33.12	MEDICAID HOSPITAL ASSESSMENT FEE	B	-800,337	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ASSISTED LIVING DEPRECIATION - BLDG	A	-138,416	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	ASSISTED LIVING DEPRECIATION - MVBLE	A	-820	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	CRNA SALARY EXPENSE	A	-180,202	ANESTHESIOLOGY	53.00	0	33.15
33.16	CRNA BENEFITS EXPENSE	A	-39,083	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	PATIENT PHONES - SALARY	A	-3,539	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PATIENT PHONES - BENEFITS	A	-768	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	EMPLOYEE BENEFITS	A	-1,821,836	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	CABLE	A	-4,791	OPERATION OF PLANT	7.00	0	33.20
33.21	RECRUITING EXPENSE	A	-5,312	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	ACCURED PTO	A	-38,117	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	LEASE DEPRECIATION - CARRY FORWARD A	A	30	CAP REL COSTS-BLDG & FIXT	1.00	9	33.23
33.24	EQUIPMENT DEPRECIATION - CARRY FORWA	A	15,476	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.24
33.25	LEASE REVENUE	B	-45,020	CAP REL COSTS-BLDG & FIXT	1.00	10	33.25
33.26	TELEPHONE EQUIPMENT	A	-269	ADULTS & PEDIATRICS	30.00	0	33.26
33.27	MARKETING	A	-179	PHYSICAL THERAPY	66.00	0	33.27
33.28	MISCELLANEOUS INCOME	B	-8,889	PHARMACY	15.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,853,616				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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2018 8:41 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	97,135	0	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	782,994	782,994	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	58,263	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,648,549	11,153	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,572,370	5,359,138	4.01
4.02	7.00	OPERATION OF PLANT	FACILITIES (SLA)	650,237	650,237	4.02
4.03	13.00	NURSING ADMINISTRATION	NURSING ADMIN (SLA)	38,785	38,785	4.03
4.04	50.00	OPERATING ROOM	OPERATING ROOM (SLA)	112,560	112,560	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY (SLA)	121,663	121,663	4.05
4.06	60.00	LABORATORY	LABORATORY (SLA)	1,118,260	1,118,260	4.06
4.07	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY (SLA)	3,168	3,168	4.07
4.08	69.00	ELECTROCARDIOLOGY	SLEEP LAB (SLA)	164,719	164,719	4.08
4.09	91.00	EMERGENCY	EMERGENCY (SLA)	1,434,663	1,434,663	4.09
4.10	190.01	MARKETING/PUBLIC RELATIONS	MARKETING (SLA)	24,606	24,606	4.10
4.11	192.00	PHYSICIANS' PRIVATE OFFICES	PHYSICIAN SERVICES (SLA)	255,843	255,843	4.11
4.12	192.01	OCCUPATIONAL MEDICINE	OCCUPATIONAL HEALTH (SLA)	26,187	26,187	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,110,002	10,103,976	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/29/2018 8:41 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	97,135	9		1.00
2.00	0	9		2.00
3.00	58,263	9		3.00
4.00	1,637,396	0		4.00
4.01	-786,768	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
5.00	1,006,026			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	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 8:41 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	30.00	ADULTS & PEDIATRICS	270,419	270,419	0	0	0	1.00
2.00	50.00	OPERATING ROOM	378,635	378,635	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	250,000	250,000	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	121,663	121,663	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	3,168	3,168	0	0	0	5.00
6.00	91.00	EMERGENCY	1,404,106	929,378	474,728	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			2,427,991	1,953,263	474,728		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	270,419		1.00
2.00	50.00	OPERATING ROOM	0	0	0	378,635		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	250,000		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	121,663		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	3,168		5.00
6.00	91.00	EMERGENCY	0	0	0	929,378		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	1,953,263		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2018 8:41 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					21	1.00
2.00	Line 1 multiplied by 15 hours per week					315	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					69	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.35	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	616.00	20.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.04	60.78	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.52	40.52	30.39			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					49,921	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					1,231	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					51,152	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					51,152	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					51,152	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					2,796	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,796	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					369	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,165	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,165	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					369	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.04	60.78	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	51,152		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,165		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	54,317		63.00
64.00	Total cost of outside supplier services (from your records)	43,779		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,796		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	369		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,165		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	369		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	369		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		Respiratory Therapy	Cost
			1.00
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	61	1.00
2.00	Line 1 multiplied by 15 hours per week	915	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	177	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.35	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,047.33	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	63.70	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	31.85	31.85	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	130,415	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	130,415	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	130,415	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	130,415	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	5,637	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	5,637	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	947	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,584	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	6,584	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.70	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	130,415	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,584	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	136,999	63.00
64.00	Total cost of outside supplier services (from your records)	133,611	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,637	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	947	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,584	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	947	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	947	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		5	1.00
2.00	Line 1 multiplied by 15 hours per week		75	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		15	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.35	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	119.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.82	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.41	38.41	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	9,180	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	9,180	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	9,180	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	9,180	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	576	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	576	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	80	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	656	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	656	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	80	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.82	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	9,180	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	656	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	9,836	63.00
64.00	Total cost of outside supplier services (from your records)	8,604	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	576	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	80	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	656	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	80	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	80	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,364,309	1,364,309				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	602,920	0	602,920			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,074,882			1,074,882		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,335,736	5,740	3,019	4,594	2,349,089	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,693,390	80,334	42,247	64,291	164,196	5.00
7.00	00700	OPERATION OF PLANT	4,937,959	298,927	129,950	239,233	159,704	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	105,976	21,248	11,174	17,005	10,685	8.00
9.00	00900	HOUSEKEEPING	370,078	12,661	6,658	10,132	64,770	9.00
10.00	01000	DIETARY	237,223	17,333	9,116	13,872	30,587	10.00
11.00	01100	CAFETERIA	368,940	38,107	20,040	30,497	62,403	11.00
13.00	01300	NURSING ADMINISTRATION	594,049	35,570	15,337	28,467	126,601	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	880,525	31,082	16,346	24,875	0	14.00
15.00	01500	PHARMACY	611,662	10,591	5,570	8,476	125,633	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,089,167	144,224	75,846	115,423	450,531	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,094,849	161,498	84,931	129,247	233,476	50.00
53.00	05300	ANESTHESIOLOGY	51,510	2,966	1,560	2,374	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,178,737	83,570	43,949	66,881	235,769	54.00
60.00	06000	LABORATORY	1,165,468	32,637	17,164	26,120	305	60.00
65.00	06500	RESPIRATORY THERAPY	498,507	1,977	1,040	1,582	78,090	65.00
66.00	06600	PHYSICAL THERAPY	643,673	40,829	21,472	32,676	131,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,997	9,266	4,873	7,416	39,084	67.00
69.00	06900	ELECTROCARDIOLOGY	421,033	17,848	9,386	14,283	91,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	248,495	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,273,960	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,843,685	0	0	0	0	73.00
73.01	03480	ONCOLOGY	182,290	13,096	6,887	10,481	38,942	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	89,707	13,597	7,150	10,881	17,742	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,657,225	76,280	40,115	61,047	251,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,796,952	1,149,381	573,830	919,853	2,313,099	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	52,471	4,897	2,575	3,919	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	136,896	177,882	18,890	142,360	28,443	192.00
192.01	19201	OCCUPATIONAL MEDICINE	68,497	10,934	5,750	8,750	7,547	192.01
192.02	19202	VACANT SPACE	0	21,215	1,875	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,054,816	1,364,309	602,920	1,074,882	2,349,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,044,458	6,044,458				5.00
7.00	00700	OPERATION OF PLANT	5,765,773	1,339,877	7,105,650			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	366,945	366,945		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	166,088	38,597	150,455	0	355,140	8.00
9.00	00900	HOUSEKEEPING	464,299	107,897	89,648	0	0	9.00
10.00	01000	DIETARY	308,131	71,606	122,735	0	0	10.00
11.00	01100	CAFETERIA	519,987	120,838	269,830	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	800,024	185,915	206,503	15,844	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	952,828	221,425	220,083	0	0	14.00
15.00	01500	PHARMACY	761,932	177,063	74,994	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,875,191	668,157	1,021,220	0	355,140	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,704,001	395,988	1,143,534	0	0	50.00
53.00	05300	ANESTHESIOLOGY	58,410	13,574	21,000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,608,906	373,889	591,741	0	0	54.00
60.00	06000	LABORATORY	1,241,694	288,554	231,096	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	581,196	135,062	14,000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	870,191	202,221	289,104	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,636	56,153	65,614	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	553,782	128,692	126,375	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	248,495	57,747	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,273,960	296,052	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,843,685	428,448	0	0	0	73.00
73.01	03480	ONCOLOGY	251,696	58,491	92,728	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	139,077	32,320	96,275	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,086,475	484,870	540,127	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,361,915	5,883,436	5,734,007	15,844	355,140	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	63,862	14,841	34,674	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	504,471	117,233	1,259,548	351,101	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	101,478	23,582	77,421	0	0	192.01
192.02	19202	VACANT SPACE	23,090	5,366	0	0	0	192.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,054,816	6,044,458	7,105,650	366,945	355,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	661,844					9.00
10.00	01000	DIETARY	13,636	516,108				10.00
11.00	01100	CAFETERIA	29,979	0	940,634			11.00
13.00	01300	NURSING ADMINISTRATION	22,943	0	42,744	1,273,973		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,452	0	0	0	1,418,788	14.00
15.00	01500	PHARMACY	8,332	0	46,190	0	12,263	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	113,462	516,108	250,898	789,413	51,543	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	127,054	0	100,399	192,614	354,869	50.00
53.00	05300	ANESTHESIOLOGY	2,333	0	6,693	88	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,745	0	106,761	0	11,308	54.00
60.00	06000	LABORATORY	25,676	0	62,360	0	6,193	60.00
65.00	06500	RESPIRATORY THERAPY	1,555	0	36,382	0	14,018	65.00
66.00	06600	PHYSICAL THERAPY	32,121	0	56,263	0	9,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,290	0	24,387	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	14,041	0	32,538	23,594	10,487	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	147,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	756,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	10,303	0	16,501	25,191	6,312	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	10,697	0	7,091	24,420	461	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	60,011	0	127,106	218,653	32,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	569,630	516,108	916,313	1,273,973	1,414,215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	3,852	0	0	0	490	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,760	0	17,959	0	2,221	192.00
192.01	19201	OCCUPATIONAL MEDICINE	8,602	0	6,362	0	1,862	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	661,844	516,108	940,634	1,273,973	1,418,788	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,080,774					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,784	6,649,916	0	6,649,916		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,878	4,027,337	0	4,027,337		50.00
53.00	05300	ANESTHESIOLOGY	0	102,098	0	102,098		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,244	2,760,594	0	2,760,594		54.00
60.00	06000	LABORATORY	0	1,855,573	0	1,855,573		60.00
65.00	06500	RESPIRATORY THERAPY	117	782,330	0	782,330		65.00
66.00	06600	PHYSICAL THERAPY	101	1,459,515	0	1,459,515		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	395,080	0	395,080		67.00
69.00	06900	ELECTROCARDIOLOGY	193	889,702	0	889,702		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	453,870	0	453,870		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,326,861	0	2,326,861		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,041,250	3,313,383	0	3,313,383		73.00
73.01	03480	ONCOLOGY	1,190	462,412	0	462,412		73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	24	310,365	0	310,365		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,163	3,562,175	0	3,562,175		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,074,944	29,351,211	0	29,351,211		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	117,719	0	117,719		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21	2,332,314	0	2,332,314		192.00
192.01	19201	OCCUPATIONAL MEDICINE	5,809	225,116	0	225,116		192.01
192.02	19202	VACANT SPACE	0	28,456	0	28,456		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,080,774	32,054,816	0	32,054,816		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,740	3,019	4,594	13,353	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	80,334	42,247	64,291	186,872	5.00
7.00	00700	OPERATION OF PLANT	0	298,927	129,950	239,233	668,110	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,248	11,174	17,005	49,427	8.00
9.00	00900	HOUSEKEEPING	0	12,661	6,658	10,132	29,451	9.00
10.00	01000	DIETARY	0	17,333	9,116	13,872	40,321	10.00
11.00	01100	CAFETERIA	0	38,107	20,040	30,497	88,644	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,570	15,337	28,467	79,374	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,082	16,346	24,875	72,303	14.00
15.00	01500	PHARMACY	0	10,591	5,570	8,476	24,637	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	144,224	75,846	115,423	335,493	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	161,498	84,931	129,247	375,676	50.00
53.00	05300	ANESTHESIOLOGY	0	2,966	1,560	2,374	6,900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,570	43,949	66,881	194,400	54.00
60.00	06000	LABORATORY	0	32,637	17,164	26,120	75,921	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,977	1,040	1,582	4,599	65.00
66.00	06600	PHYSICAL THERAPY	0	40,829	21,472	32,676	94,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,266	4,873	7,416	21,555	67.00
69.00	06900	ELECTROCARDIOLOGY	0	17,848	9,386	14,283	41,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	13,096	6,887	10,481	30,464	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	13,597	7,150	10,881	31,628	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	76,280	40,115	61,047	177,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,149,381	573,830	919,853	2,643,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	4,897	2,575	3,919	11,391	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	177,882	18,890	142,360	339,132	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	10,934	5,750	8,750	25,434	192.01
192.02	19202	VACANT SPACE	0	21,215	1,875	0	23,090	192.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,364,309	602,920	1,074,882	3,042,111	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,353					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	933	187,805				5.00
7.00	00700	OPERATION OF PLANT	908	41,641	710,659			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	36,699	36,699		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	61	1,199	15,048	0	65,735	8.00
9.00	00900	HOUSEKEEPING	368	3,352	8,966	0	0	9.00
10.00	01000	DIETARY	174	2,225	12,275	0	0	10.00
11.00	01100	CAFETERIA	355	3,754	26,987	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	720	5,776	20,653	1,585	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,879	22,011	0	0	14.00
15.00	01500	PHARMACY	714	5,501	7,500	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,559	20,759	102,135	0	65,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,327	12,303	114,369	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	422	2,100	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,340	11,616	59,182	0	0	54.00
60.00	06000	LABORATORY	2	8,965	23,113	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	444	4,196	1,400	0	0	65.00
66.00	06600	PHYSICAL THERAPY	748	6,283	28,914	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	1,745	6,562	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	519	3,998	12,639	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,794	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,198	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,311	0	0	0	73.00
73.01	03480	ONCOLOGY	221	1,817	9,274	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	101	1,004	9,629	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,432	15,064	54,020	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,148	182,802	573,476	1,585	65,735	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	461	3,468	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162	3,642	125,972	35,114	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	43	733	7,743	0	0	192.01
192.02	19202	VACANT SPACE	0	167	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,353	187,805	710,659	36,699	65,735	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	42,137					9.00
10.00	01000	DIETARY	868	55,863				10.00
11.00	01100	CAFETERIA	1,909	0	121,649			11.00
13.00	01300	NURSING ADMINISTRATION	1,461	0	5,528	115,097		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,557	0	0	0	102,750	14.00
15.00	01500	PHARMACY	530	0	5,974	0	888	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,224	55,863	32,447	71,319	3,733	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,087	0	12,984	17,402	25,700	50.00
53.00	05300	ANESTHESIOLOGY	149	0	866	8	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,186	0	13,807	0	819	54.00
60.00	06000	LABORATORY	1,635	0	8,065	0	449	60.00
65.00	06500	RESPIRATORY THERAPY	99	0	4,705	0	1,015	65.00
66.00	06600	PHYSICAL THERAPY	2,045	0	7,276	0	689	66.00
67.00	06700	OCCUPATIONAL THERAPY	464	0	3,154	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	894	0	4,208	2,132	759	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	54,813	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	656	0	2,134	2,276	457	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	681	0	917	2,206	33	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,821	0	16,438	19,754	2,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,266	55,863	118,503	115,097	102,419	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	245	0	0	0	35	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,078	0	2,323	0	161	192.00
192.01	19201	OCCUPATIONAL MEDICINE	548	0	823	0	135	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,137	55,863	121,649	115,097	102,750	202.00

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		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	45,744					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	372	697,639	0	697,639		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	376	568,224	0	568,224		50.00
53.00	05300	ANESTHESIOLOGY	0	10,445	0	10,445		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95	285,445	0	285,445		54.00
60.00	06000	LABORATORY	0	118,150	0	118,150		60.00
65.00	06500	RESPIRATORY THERAPY	5	16,463	0	16,463		65.00
66.00	06600	PHYSICAL THERAPY	4	140,936	0	140,936		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,702	0	33,702		67.00
69.00	06900	ELECTROCARDIOLOGY	8	66,674	0	66,674		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,485	0	12,485		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	64,011	0	64,011		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,071	57,382	0	57,382		73.00
73.01	03480	ONCOLOGY	50	47,349	0	47,349		73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	1	46,200	0	46,200		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	515	290,859	0	290,859		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,497	2,455,964	0	2,455,964		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	15,600	0	15,600		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	511,585	0	511,585		192.00
192.01	19201	OCCUPATIONAL MEDICINE	246	35,705	0	35,705		192.01
192.02	19202	VACANT SPACE	0	23,257	0	23,257		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	45,744	3,042,111	0	3,042,111		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	207,006					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	173,953				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			203,787			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	871	871	871	10,709,652		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,189	12,189	12,189	748,580	-6,044,458	5.00
7.00	00700	OPERATION OF PLANT	45,356	37,493	45,356	728,102	0	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,224	3,224	3,224	48,713	0	8.00
9.00	00900	HOUSEKEEPING	1,921	1,921	1,921	295,292	0	9.00
10.00	01000	DIETARY	2,630	2,630	2,630	139,449	0	10.00
11.00	01100	CAFETERIA	5,782	5,782	5,782	284,501	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,397	4,425	5,397	577,185	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,716	4,716	4,716	0	0	14.00
15.00	01500	PHARMACY	1,607	1,607	1,607	572,770	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,883	21,883	21,883	2,053,985	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,504	24,504	24,504	1,064,435	0	50.00
53.00	05300	ANESTHESIOLOGY	450	450	450	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,680	12,680	12,680	1,074,889	0	54.00
60.00	06000	LABORATORY	4,952	4,952	4,952	1,390	0	60.00
65.00	06500	RESPIRATORY THERAPY	300	300	300	356,018	0	65.00
66.00	06600	PHYSICAL THERAPY	6,195	6,195	6,195	599,705	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,406	1,406	1,406	178,188	0	67.00
69.00	06900	ELECTROCARDIOLOGY	2,708	2,708	2,708	415,931	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1,987	1,987	1,987	177,541	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,063	2,063	2,063	80,889	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,574	11,574	11,574	1,148,010	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,395	165,560	174,395	10,545,573	-6,044,458	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	743	743	743	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,990	5,450	26,990	129,673	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,659	1,659	1,659	34,406	0	192.01
192.02	19202	VACANT SPACE	3,219	541	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,364,309	602,920	1,074,882	2,349,089		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.590674	3.465994	5.274537	0.219343		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				13,353		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001247		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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,010,358					5.00
7.00	00700	OPERATION OF PLANT	5,765,773	152,262				7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	7,863	22,512			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	166,088	3,224	0	2,207		8.00
9.00	00900	HOUSEKEEPING	464,299	1,921	0	0	127,647	9.00
10.00	01000	DIETARY	308,131	2,630	0	0	2,630	10.00
11.00	01100	CAFETERIA	519,987	5,782	0	0	5,782	11.00
13.00	01300	NURSING ADMINISTRATION	800,024	4,425	972	0	4,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	952,828	4,716	0	0	4,716	14.00
15.00	01500	PHARMACY	761,932	1,607	0	0	1,607	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,875,191	21,883	0	2,207	21,883	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,704,001	24,504	0	0	24,504	50.00
53.00	05300	ANESTHESIOLOGY	58,410	450	0	0	450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,608,906	12,680	0	0	12,680	54.00
60.00	06000	LABORATORY	1,241,694	4,952	0	0	4,952	60.00
65.00	06500	RESPIRATORY THERAPY	581,196	300	0	0	300	65.00
66.00	06600	PHYSICAL THERAPY	870,191	6,195	0	0	6,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,636	1,406	0	0	1,406	67.00
69.00	06900	ELECTROCARDIOLOGY	553,782	2,708	0	0	2,708	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	248,495	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,273,960	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,843,685	0	0	0	0	73.00
73.01	03480	ONCOLOGY	251,696	1,987	0	0	1,987	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	139,077	2,063	0	0	2,063	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,086,475	11,574	0	0	11,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,317,457	122,870	972	2,207	109,862	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	63,862	743	0	0	743	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	504,471	26,990	21,540	0	15,383	192.00
192.01	19201	OCCUPATIONAL MEDICINE	101,478	1,659	0	0	1,659	192.01
192.02	19202	VACANT SPACE	23,090	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,044,458	7,105,650	366,945	355,140	661,844	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.232387	46.667258	16.299973	160.915270	5.184955	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	187,805	710,659	36,699	65,735	42,137	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007220	4.667343	1.630197	29.784776	0.330106	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 8:41 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	8,724					10.00
11.00	01100	CAFETERIA	0	14,194				11.00
13.00	01300	NURSING ADMINISTRATION	0	645	115,661			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,388,169		14.00
15.00	01500	PHARMACY	0	697	0	20,642	1,913,668	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,724	3,786	71,669	86,760	15,554	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,515	17,487	597,332	15,720	50.00
53.00	05300	ANESTHESIOLOGY	0	101	8	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,611	0	19,034	3,973	54.00
60.00	06000	LABORATORY	0	941	0	10,425	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	549	0	23,596	207	65.00
66.00	06600	PHYSICAL THERAPY	0	849	0	16,015	179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	368	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	491	2,142	17,652	342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	248,495	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,273,960	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,843,684	73.00
73.01	03480	ONCOLOGY	0	249	2,287	10,625	2,107	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	107	2,217	776	42	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,918	19,851	55,160	21,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,724	13,827	115,661	2,380,472	1,903,345	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	0	824	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	271	0	3,739	38	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	96	0	3,134	10,285	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	516,108	940,634	1,273,973	1,418,788	1,080,774	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	59.159560	66.269832	11.014715	0.594090	0.564766	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,863	121,649	115,097	102,750	45,744	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.403370	8.570452	0.995124	0.043025	0.023904	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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 8:41 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	6,649,916		6,649,916	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,027,337		4,027,337	0	0	50.00
53.00	05300	ANESTHESIOLOGY	102,098		102,098	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,760,594		2,760,594	0	0	54.00
60.00	06000	LABORATORY	1,855,573		1,855,573	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	782,330	0	782,330	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,459,515	0	1,459,515	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	395,080	0	395,080	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	889,702		889,702	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	453,870		453,870	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,861		2,326,861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,313,383		3,313,383	0	0	73.00
73.01	03480	ONCOLOGY	462,412		462,412	0	0	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	310,365		310,365	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,562,175		3,562,175	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,396,525		1,396,525		0	92.00
200.00		Subtotal (see instructions)	30,747,736	0	30,747,736	0	0	200.00
201.00		Less Observation Beds	1,396,525		1,396,525		0	201.00
202.00		Total (see instructions)	29,351,211	0	29,351,211	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,421,080		2,421,080			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,738,112	15,823,458	23,561,570	0.170928	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	343,082	484,267	827,349	0.123404	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	396,333	9,002,858	9,399,191	0.293705	0.000000	54.00
60.00	06000	LABORATORY	927,012	5,231,545	6,158,557	0.301300	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	471,693	667,733	1,139,426	0.686600	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	862,746	1,619,241	2,481,987	0.588043	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	378,266	297,700	675,966	0.584467	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	287,992	3,923,089	4,211,081	0.211276	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	938,538	942,021	1,880,559	0.241348	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,994,809	2,588,273	11,583,082	0.200884	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,653,065	7,646,307	10,299,372	0.321707	0.000000	73.00
73.01	03480	ONCOLOGY	0	1,338,068	1,338,068	0.345582	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	580,964	580,964	0.534224	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	471,743	19,574,735	20,046,478	0.177696	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,671	2,620,414	2,630,085	0.530981	0.000000	92.00
200.00		Subtotal (see instructions)	26,894,142	72,340,673	99,234,815			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	26,894,142	72,340,673	99,234,815			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 8:41 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	03480	ONCOLOGY	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,649,916		6,649,916	0	6,649,916	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,027,337		4,027,337	0	4,027,337	50.00
53.00	05300	ANESTHESIOLOGY	102,098		102,098	0	102,098	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,760,594		2,760,594	0	2,760,594	54.00
60.00	06000	LABORATORY	1,855,573		1,855,573	0	1,855,573	60.00
65.00	06500	RESPIRATORY THERAPY	782,330	0	782,330	0	782,330	65.00
66.00	06600	PHYSICAL THERAPY	1,459,515	0	1,459,515	0	1,459,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	395,080	0	395,080	0	395,080	67.00
69.00	06900	ELECTROCARDIOLOGY	889,702		889,702	0	889,702	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	453,870		453,870	0	453,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,861		2,326,861	0	2,326,861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,313,383		3,313,383	0	3,313,383	73.00
73.01	03480	ONCOLOGY	462,412		462,412	0	462,412	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	310,365		310,365	0	310,365	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,562,175		3,562,175	0	3,562,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,396,525		1,396,525		1,396,525	92.00
200.00		Subtotal (see instructions)	30,747,736	0	30,747,736	0	30,747,736	200.00
201.00		Less Observation Beds	1,396,525		1,396,525		1,396,525	201.00
202.00		Total (see instructions)	29,351,211	0	29,351,211	0	29,351,211	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,421,080		2,421,080			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,738,112	15,823,458	23,561,570	0.170928	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	343,082	484,267	827,349	0.123404	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	396,333	9,002,858	9,399,191	0.293705	0.000000	54.00
60.00	06000	LABORATORY	927,012	5,231,545	6,158,557	0.301300	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	471,693	667,733	1,139,426	0.686600	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	862,746	1,619,241	2,481,987	0.588043	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	378,266	297,700	675,966	0.584467	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	287,992	3,923,089	4,211,081	0.211276	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	938,538	942,021	1,880,559	0.241348	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,994,809	2,588,273	11,583,082	0.200884	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,653,065	7,646,307	10,299,372	0.321707	0.000000	73.00
73.01	03480	ONCOLOGY	0	1,338,068	1,338,068	0.345582	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	580,964	580,964	0.534224	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	471,743	19,574,735	20,046,478	0.177696	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,671	2,620,414	2,630,085	0.530981	0.000000	92.00
200.00		Subtotal (see instructions)	26,894,142	72,340,673	99,234,815			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	26,894,142	72,340,673	99,234,815			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 8:41 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	568,224	23,561,570	0.024117	3,602,029	86,870	50.00
53.00	05300	ANESTHESIOLOGY	10,445	827,349	0.012625	153,326	1,936	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	285,445	9,399,191	0.030369	181,925	5,525	54.00
60.00	06000	LABORATORY	118,150	6,158,557	0.019185	512,873	9,839	60.00
65.00	06500	RESPIRATORY THERAPY	16,463	1,139,426	0.014449	221,252	3,197	65.00
66.00	06600	PHYSICAL THERAPY	140,936	2,481,987	0.056784	369,060	20,957	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,702	675,966	0.049858	180,135	8,981	67.00
69.00	06900	ELECTROCARDIOLOGY	66,674	4,211,081	0.015833	199,473	3,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,485	1,880,559	0.006639	417,618	2,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,011	11,583,082	0.005526	4,044,743	22,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,382	10,299,372	0.005571	1,276,722	7,113	73.00
73.01	03480	ONCOLOGY	47,349	1,338,068	0.035386	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	46,200	580,964	0.079523	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	290,859	20,046,478	0.014509	10,034	146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	146,508	2,630,085	0.055705	546	30	92.00
200.00		Total (lines 50 through 199)	1,904,833	96,813,735		11,169,736	172,876	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 8:41 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	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 8:41 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	0	0	23,561,570	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	827,349	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,399,191	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,158,557	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,139,426	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,481,987	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	675,966	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,211,081	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,880,559	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,583,082	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,299,372	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	1,338,068	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	580,964	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	20,046,478	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,630,085	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	96,813,735		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 8:41 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	3,602,029	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	153,326	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	181,925	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	512,873	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	221,252	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	369,060	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	180,135	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	199,473	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	417,618	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,044,743	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,276,722	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	10,034	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	546	0	0	0	92.00
200.00		Total (lines 50 through 199)		11,169,736	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 8:41 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	0.170928	0	4,172,309	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.123404	0	91,441	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293705	0	3,314,742	0	0	54.00
60.00	06000	LABORATORY	0.301300	0	1,679,924	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.686600	0	275,279	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.588043	0	676,749	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584467	0	104,479	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.211276	0	1,572,885	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241348	0	186,437	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.200884	0	558,115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321707	0	3,614,948	611	0	73.00
73.01	03480	ONCOLOGY	0.345582	0	833,425	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.534224	0	301,785	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.177696	0	6,465,637	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.530981	0	1,453,095	0	0	92.00
200.00		Subtotal (see instructions)		0	25,301,250	611	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	25,301,250	611	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	713,164	0		50.00
53.00	05300	ANESTHESIOLOGY	11,284	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	973,556	0		54.00
60.00	06000	LABORATORY	506,161	0		60.00
65.00	06500	RESPIRATORY THERAPY	189,007	0		65.00
66.00	06600	PHYSICAL THERAPY	397,958	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	61,065	0		67.00
69.00	06900	ELECTROCARDIOLOGY	332,313	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,996	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	112,116	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,162,954	197		73.00
73.01	03480	ONCOLOGY	288,017	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	161,221	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,148,918	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	771,566	0		92.00
200.00		Subtotal (see instructions)	6,874,296	197		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,874,296	197		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 8:41 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	0.170928	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.123404	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293705	0	0	0	0	54.00
60.00	06000	LABORATORY	0.301300	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.686600	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.588043	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584467	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.211276	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241348	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.200884	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321707	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.345582	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.534224	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.177696	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.530981	0	0	0	0	92.00
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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 8:41 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170928	0	120,072	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.123404	0	10,017	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293705	0	67,209	0	0	54.00
60.00	06000	LABORATORY	0.301300	0	31,392	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.686600	0	451	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.588043	0	5,372	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584467	0	253	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.211276	0	16,193	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241348	0	5,829	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.200884	0	800	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321707	0	34,129	0	0	73.00
73.01	03480	ONCOLOGY	0.345582	0	438	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.534224	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.177696	0	243,425	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.530981	0	11,074	0	0	92.00
200.00		Subtotal (see instructions)		0	546,654	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	546,654	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	20,524	0		50.00
53.00	05300	ANESTHESIOLOGY	1,236	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,740	0		54.00
60.00	06000	LABORATORY	9,458	0		60.00
65.00	06500	RESPIRATORY THERAPY	310	0		65.00
66.00	06600	PHYSICAL THERAPY	3,159	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	148	0		67.00
69.00	06900	ELECTROCARDIOLOGY	3,421	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,407	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	161	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,980	0		73.00
73.01	03480	ONCOLOGY	151	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	43,256	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,880	0		92.00
200.00		Subtotal (see instructions)	119,831	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	119,831	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 8:41 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,653	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,952	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)	2,207	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	586	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	115	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,430	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)	586	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)	6,649,916	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)	17,827	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)	1,116,302	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,533,614	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)	5,533,614	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,874.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,680,578	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)	2,680,578	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 8:41 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,685,050	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,365,628	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)	1,098,475	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)	1,098,475	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)	745	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,874.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,396,525	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 8:41 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	697,639	6,649,916	0.104909	1,396,525	146,508	90.00
91.00	Nursing School cost	0	6,649,916	0.000000	1,396,525	0	91.00
92.00	Allied health cost	0	6,649,916	0.000000	1,396,525	0	92.00
93.00	All other Medical Education	0	6,649,916	0.000000	1,396,525	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,653	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,952	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)	2,207	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	586	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	115	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)	6,649,916	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)	17,827	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)	1,116,302	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,533,614	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)	5,533,614	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,874.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,122	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)	13,122	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	70,339	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	83,461	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	745	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,874.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,396,525	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	697,639	6,649,916	0.104909	1,396,525	146,508	90.00
91.00	Nursing School cost	0	6,649,916	0.000000	1,396,525	0	91.00
92.00	Allied health cost	0	6,649,916	0.000000	1,396,525	0	92.00
93.00	All other Medical Education	0	6,649,916	0.000000	1,396,525	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 8:41 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		1,248,996		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170928	3,602,029	615,688	50.00
53.00	05300	ANESTHESIOLOGY	0.123404	153,326	18,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293705	181,925	53,432	54.00
60.00	06000	LABORATORY	0.301300	512,873	154,529	60.00
65.00	06500	RESPIRATORY THERAPY	0.686600	221,252	151,912	65.00
66.00	06600	PHYSICAL THERAPY	0.588043	369,060	217,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584467	180,135	105,283	67.00
69.00	06900	ELECTROCARDIOLOGY	0.211276	199,473	42,144	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241348	417,618	100,791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.200884	4,044,743	812,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321707	1,276,722	410,730	73.00
73.01	03480	ONCOLOGY	0.345582	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.534224	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.177696	10,034	1,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.530981	546	290	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,169,736	2,685,050	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)		11,169,736		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3

Component CCN: 15-Z311 | Date/Time Prepared: 5/29/2018 8:41 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170928	12,547	2,145	50.00
53.00	05300	ANESTHESIOLOGY	0.123404	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293705	26,983	7,925	54.00
60.00	06000	LABORATORY	0.301300	142,863	43,045	60.00
65.00	06500	RESPIRATORY THERAPY	0.686600	113,746	78,098	65.00
66.00	06600	PHYSICAL THERAPY	0.588043	178,483	104,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584467	82,486	48,210	67.00
69.00	06900	ELECTROCARDIOLOGY	0.211276	1,971	416	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241348	2,422	585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.200884	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321707	278,807	89,694	73.00
73.01	03480	ONCOLOGY	0.345582	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.534224	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.177696	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.530981	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		840,308	375,074	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)		840,308		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,872		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170928	128,845	22,023	50.00
53.00	05300	ANESTHESIOLOGY	0.123404	5,936	733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293705	1,839	540	54.00
60.00	06000	LABORATORY	0.301300	227	68	60.00
65.00	06500	RESPIRATORY THERAPY	0.686600	5,506	3,780	65.00
66.00	06600	PHYSICAL THERAPY	0.588043	6,280	3,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584467	1,578	922	67.00
69.00	06900	ELECTROCARDIOLOGY	0.211276	219	46	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241348	5,469	1,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.200884	138,824	27,888	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321707	25,254	8,124	73.00
73.01	03480	ONCOLOGY	0.345582	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.534224	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.177696	6,763	1,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.530981	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		326,740	70,339	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)		326,740		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 8:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,874,493	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)	6,874,493	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)	6,943,238	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)	33,889	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,712,669	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)	2,196,680	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)	2,196,680	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,196,680	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)	725,447	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	471,541	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	531,097	36.00
37.00	Subtotal (see instructions)	2,668,221	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)	2,668,221	40.00
40.01	Sequestration adjustment (see instructions)	53,364	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,323,214	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	291,643	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	237,676	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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2018 8:41 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		4,579,956		2,323,214	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	07/07/2017	102,200		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)		102,200		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)		4,682,156		2,323,214	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		228,084		291,643	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,910,240		2,614,857	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 8:41 am

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		1,028,015		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)		1,028,015		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		415,919		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,443,934		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: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 8:41 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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/29/2018 8:41 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)	1,109,460	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)	378,825	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	586	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)	1,488,285	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,488,285	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)	1,488,285	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,121	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)	1,472,164	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)	1,905	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,238	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,473,402	0	19.00
19.01	Sequestration adjustment (see instructions)	29,468	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,028,015	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)	415,919	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	33,031	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: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 8:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,365,628	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)	5,365,628	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,419,284	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)	5,419,284	19.00
20.00	Deductibles (exclude professional component)	437,325	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,981,959	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,981,959	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	43,831	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	28,490	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,264	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,010,449	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)	5,010,449	30.00
30.01	Sequestration adjustment (see instructions)	100,209	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	4,682,156	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)	228,084	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	177,898	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 8:41 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	23,243,655	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	5,063,401	0	0	0	4.00
5.00	Other receivable	-1,096,050	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	692,457	0	0	0	7.00
8.00	Prepaid expenses	188,845	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)	28,092,308	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,767,795	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,098,521	0	0	0	17.00
18.00	Accumulated depreciation	-969,835	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	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	11,138,928	0	0	0	23.00
24.00	Accumulated depreciation	-9,070,336	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)	12,965,073	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	680,557	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	14,403,983	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,084,540	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,141,921	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,411,245	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,128,192	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	3,755,426	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,294,863	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,655,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	421,383	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,076,383	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,371,246	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	32,770,675				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)	32,770,675	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,141,921	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 8:41 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		31,015,840		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,820,229				2.00
3.00	Total (sum of line 1 and line 2)		32,836,069		0		3.00
4.00	ROUNDING	11		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)		11		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,836,080		0		11.00
12.00	TEMP RESTRICTED	21,684		0		0	12.00
13.00	PERM RESTRICTED	43,721		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)		65,405		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,770,675		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	TEMP RESTRICTED		0		12.00
13.00	PERM RESTRICTED		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: 15-1311 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2018 8:41 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,421,080		2,421,080	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)	2,421,080		2,421,080	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,421,080		2,421,080	17.00
18.00	Ancillary services	23,991,647	50,145,524	74,137,171	18.00
19.00	Outpatient services	481,414	22,195,149	22,676,563	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	2,212,476	2,212,476	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,894,141	74,553,149	101,447,290	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,908,432		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		35,908,432		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/29/2018 8:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	101,447,290	1.00
2.00	Less contractual allowances and discounts on patients' accounts	65,076,286	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,371,004	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,908,432	4.00
5.00	Net income from service to patients (line 3 minus line 4)	462,572	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	1,357,657	24.00
25.00	Total other income (sum of lines 6-24)	1,357,657	25.00
26.00	Total (line 5 plus line 25)	1,820,229	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,820,229	29.00