

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 8:23 am
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PART I - COST REPORT STATUS

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

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

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

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

Date: 5/30/2018 Time: 8:23 am

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 METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,149,911	138,123	0	-479,582	1.00
2.00 Subprovider - IPF	0	43,184	0		95,493	2.00
3.00 Subprovider - IRF	0	68,365	0		33,140	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
200.00 Total	0	1,261,460	138,124	0	-350,949	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 8:22 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 600 GRANT STREET			PO Box:						1.00	
2.00	City: GARY			State: IN		Zip Code: 46402		County: LAKE		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00		
							V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		METHODIST HOSPITALS, INC	150002	23844	1	01/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		GERIATRIC PSYCH	15S002	23844	4	01/01/2012	N	P	0	4.00
5.00	Subprovider - IRF		REHABILITATION	15T002	23844	5	01/01/1984	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		METHODIST HOME CARE SERVICES	157536	23844		02/12/2002	N	P	0	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.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			3,171	13,621	0	1,331	9,149	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.			88	533	0	0	303		25.00	

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		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			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.					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	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(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.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria 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)	Y				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	2		60.01
		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
61.01	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

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
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	
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.						61.10	0.00
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.						61.20	0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
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) <u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						62.01	0.00
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)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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	
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)	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	67.00
		1.00	2.00	3.00	4.00	5.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00	
71.00	If line 70 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)			N	0	71.00	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00

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		1.00	2.00	3.00	
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)	N		0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital 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.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00	
					1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00	
					1.00	2.00	3.00	
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,879,088		0		217,011		118.01
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
DO NOT USE THIS LINE								
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		119.00 120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 8:22 am	
		1.00		2.00			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	
						1.00	
						Beginning	
						Ending	
						1.00	
						2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2017		12/30/2017		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 8:22 am
		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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 8:22 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/12/2018			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.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/20/2018	Y	04/20/2018		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: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 8:22 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		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 8:22 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.	DI RECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
	Line Number				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	377	137,605	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		377	137,605	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	33	12,045	0.00	0	8.00
8.01 NEONATAL ICU	31.01	35	12,775	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		445	162,425	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF	41.00	39	14,235		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		498			0	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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	27,937	3,165	72,236			1.00
2.00 HMO and other (see instructions)	15,196	24,014				2.00
3.00 HMO IPF Subprovider	36	0				3.00
4.00 HMO IRF Subprovider	0	836				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	27,937	3,165	72,236			7.00
8.00 INTENSIVE CARE UNIT	3,570	0	8,536			8.00
8.01 NEONATAL ICU	0	0	2,820			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	2,849			13.00
14.00 Total (see instructions)	31,507	3,165	86,441	2.94	2,063.06	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	925	619	2,343	0.00	12.87	16.00
17.00 SUBPROVIDER - IRF	5,800	88	9,525	0.00	43.02	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	7,434	0	21,066	0.00	25.93	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)				2.94	2,144.88	27.00
28.00 Observation Bed Days		0	18,479			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	93	106			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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	5,264	396	14,473	1.00
2.00	HMO and other (see instructions)			1,870	3,862		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				53		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL ICU						8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	5,264	396	14,473	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	65	0	202	16.00
17.00	SUBPROVIDER - IRF	0.00	0	377	4	591	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2018 8:22 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	151,936,992	-350,875	151,586,117	4,461,361.00	33.98
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		210,061	0	210,061	6,240.00	33.66
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		30,995,412	131,352	31,126,764	582,979.00	53.39
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		865,624	0	865,624	6,445.00	134.31
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		36,684,329	0	36,684,329		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		7,241,789	0	7,241,789		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2018 8:22 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,774,019	-121,305	1,652,714	35,729.00	46.26	26.00
27.00	Administrative & General	5.00	21,320,696	-510,954	20,809,742	659,216.00	31.57	27.00
28.00	Administrative & General under contract (see inst.)		1,579,643	0	1,579,643	7,232.00	218.42	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,869,603	0	3,869,603	163,718.00	23.64	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	4,557,455	-12,988	4,544,467	292,874.00	15.52	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,943,449	-867,346	2,076,103	122,482.00	16.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	323,846	850,662	1,174,508	68,661.00	17.11	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,931,939	-20,209	2,911,730	63,165.00	46.10	38.00
39.00	Central Services and Supply	14.00	524,233	-1,165	523,068	27,026.00	19.35	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,026,695	0	2,026,695	83,117.00	24.38	41.00
42.00	Social Service	17.00	17,205	465,581	482,786	15,285.00	31.59	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2018 8:22 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	153,306,574	-350,875	152,955,699	4,462,353.00	34.28	1.00
2.00	Excluded area salaries (see instructions)	30,995,412	131,352	31,126,764	582,979.00	53.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)	122,311,162	-482,227	121,828,935	3,879,374.00	31.40	3.00
4.00	Subtotal other wages & related costs (see inst.)	865,624	0	865,624	6,445.00	134.31	4.00
5.00	Subtotal wage-related costs (see inst.)	36,684,329	0	36,684,329	0.00	30.11	5.00
6.00	Total (sum of lines 3 thru 5)	159,861,115	-482,227	159,378,888	3,885,819.00	41.02	6.00
7.00	Total overhead cost (see instructions)	41,868,783	-217,724	41,651,059	1,538,505.00	27.07	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2018 8:22 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,952,275	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	7,217,360	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	18,147,555	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	3,006,535	9.00
10.00	Dental, Hearing and Vision Plan	1,012,377	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	523,976	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,207,995	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	10,419,991	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	118,311	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	319,743	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	43,926,118	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/30/2018 8:22 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	43,926,118	1.00
2.00	Hospital	0	43,926,118	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0002 Component CCN: 15-7536		Period: From 01/01/2017 To 12/31/2017		Worksheet S-4 Date/Time Prepared: 5/30/2018 8:22 am	
				Home Health Agency I		PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	349.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			6.41	0.00	6.41	
6.00	Direct Nursing Service			10.11	0.00	10.11	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			4.29	0.00	4.29	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			1.05	0.00	1.05	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.46	0.00	0.46	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.05	0.00	0.05	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			2.24	0.00	2.24	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23844			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,936	533	143	158	3,770	
22.00	Skilled Nursing Visit Charges	487,974	88,867	23,937	26,192	626,970	
23.00	Physical Therapy Visits	1,944	54	33	78	2,109	
24.00	Physical Therapy Visit Charges	350,658	9,716	6,042	13,972	380,388	
25.00	Occupational Therapy Visits	458	38	0	21	517	
26.00	Occupational Therapy Visit Charges	83,681	6,837	0	3,796	94,314	
27.00	Speech Pathology Visits	70	14	0	5	89	
28.00	Speech Pathology Visit Charges	13,567	2,632	0	940	17,139	
29.00	Medical Social Service Visits	12	1	2	1	16	
30.00	Medical Social Service Visit Charges	3,201	268	536	253	4,258	
31.00	Home Health Aide Visits	743	153	3	34	933	
32.00	Home Health Aide Visit Charges	54,877	11,299	225	2,498	68,899	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,163	793	181	297	7,434	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	993,958	119,619	30,740	47,651	1,191,968	
36.00	Total Number of Episodes (standard/non outlier)	331		69	17	417	
37.00	Total Number of Outlier Episodes		17		2	19	
38.00	Total Non-Routine Medical Supply Charges	32,093	12,908	3,473	1,466	49,940	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/30/2018 8:22 am
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.234617	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			89,148,443	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			273,092,506	6.00	
7.00	Medicaid cost (line 1 times line 6)			64,072,144	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	17,097,384	19,786,960	36,884,344	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,011,337	19,786,960	23,798,297	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	4,011,337	19,786,960	23,798,297	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)			23,417,425	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			2,056,467	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			3,163,794	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			20,253,631	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			5,859,173	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			29,657,470	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			29,657,470	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	22,121,550	22,121,550	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,774,019	25,480,056	27,254,075	218,872	4.00
5.01	00550	DATA PROCESSING	4,041,195	9,177,998	13,219,193	-2,407,647	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,005,062	2,420,728	3,425,790	-74,554	5.02
5.03	00570	ADMINISTRATIVE	1,972,452	447,428	2,419,880	-1,028	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,123,372	2,358,328	4,481,700	-11,961	5.04
5.05	00590	OTHER A&G	11,590,657	20,551,371	32,142,028	-12,662,008	5.05
5.06	00592	PATIENT TRANSPORTATION	587,958	70,692	658,650	-30,675	5.06
7.00	00700	OPERATION OF PLANT	3,869,603	10,753,190	14,622,793	4,239,979	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,353,425	1,353,425	0	8.00
9.00	00900	HOUSEKEEPING	4,557,455	1,299,539	5,856,994	-48,136	9.00
10.00	01000	DIETARY	2,943,449	2,697,718	5,641,167	-1,893,346	10.00
11.00	01100	CAFETERIA	323,846	39,549	363,395	1,796,003	11.00
13.00	01300	NURSING ADMINISTRATION	2,931,939	627,215	3,559,154	-48,656	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	524,233	1,844,110	2,368,343	-412,427	14.00
15.00	01500	PHARMACY	0	15,347,018	15,347,018	-9,857,712	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,026,695	807,801	2,834,496	-3,284	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	465,581	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	17,205	38,034	55,239	-249	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	210,423	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	46,752	22.00
23.00	02300	PARAMED PROGRAM	398,549	73,360	471,909	158,827	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,300,035	7,450,050	37,750,085	-2,016,534	30.00
31.00	03100	INTENSIVE CARE UNIT	6,703,231	2,107,085	8,810,316	-748,864	31.00
31.01	03101	NEONATAL ICU	2,047,370	900,152	2,947,522	-28,451	31.01
40.00	04000	SUBPROVIDER - I PF	1,019,387	98,895	1,118,282	-5,367	40.00
41.00	04100	SUBPROVIDER - I RF	2,976,855	514,111	3,490,966	-69,601	41.00
43.00	04300	NURSERY	694,855	290,348	985,203	-86,927	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,427,978	18,944,201	23,372,179	-16,514,432	50.00
50.01	05001	ENDOSCOPY	1,234,820	2,366,985	3,601,805	-728,461	50.01
51.00	05100	RECOVERY ROOM	1,168,467	155,245	1,323,712	-17,125	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,829,485	553,841	3,383,326	-215,612	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,006	2,433,179	4,860,185	-719,229	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,402,719	891,261	2,293,980	-507,082	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	463,510	1,302,295	1,765,805	-384,370	55.00
56.00	05600	RADIOISOTOPE	598,750	1,214,610	1,813,360	-125,730	56.00
57.00	05700	CT SCAN	1,095,282	1,173,826	2,269,108	-533,946	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	442,254	788,660	1,230,914	-583,195	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,060,816	6,513,465	8,574,281	-5,710,400	59.00
60.00	06000	LABORATORY	3,541,429	6,714,584	10,256,013	-52,291	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,180,582	392,470	1,573,052	-4,670	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,420,938	1,093,270	3,514,208	-342,494	65.00
66.00	06600	PHYSICAL THERAPY	1,544,468	130,708	1,675,176	-2,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,228,704	107,045	1,335,749	-464	67.00
68.00	06800	SPEECH PATHOLOGY	419,301	80,885	500,186	-4,672	68.00
69.00	06900	ELECTROCARDIOLOGY	644,586	234,761	879,347	-118,455	69.00
69.01	06901	CARDIAC REHAB	395,078	338,434	733,512	-117,257	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	883,233	6,628,914	7,512,147	-6,385,419	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,044,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,726,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	384,721	855,934	1,240,655	12,525,435	73.00
74.00	07400	RENAL DIALYSIS	0	2,108,726	2,108,726	-2,263	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,884,665	2,369,506	5,254,171	-256,935	90.00
91.00	09100	EMERGENCY	7,228,157	3,453,285	10,681,442	-974,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,012,787	348,334	2,361,121	-6,829	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,349,158	167,942,625	295,291,783	2,839,888	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	45,589	180,112	225,701	-11,234	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
5/30/2018 8:22 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	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,804,728	19,422,591	41,227,319	-886,999	40,340,320	192.00
192.01	19201	OTHER NON-REIMBURSABLE	2,575,181	3,441,571	6,016,752	-1,941,653	4,075,099	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	162,336	52,960	215,296	-2	215,294	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	151,936,992	191,039,859	342,976,851	0	342,976,851	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
5/30/2018 8:22 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	-1,866,855	20,254,695	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,408,920	35,881,867	4.00
5.01	00550	DATA PROCESSING	-177,723	10,633,823	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	3,351,236	5.02
5.03	00570	ADMITTING	0	2,418,852	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-61,481	4,408,258	5.04
5.05	00590	OTHER A&G	-504,224	18,975,796	5.05
5.06	00592	PATIENT TRANSPORTATION	0	627,975	5.06
7.00	00700	OPERATION OF PLANT	0	18,862,772	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,353,425	8.00
9.00	00900	HOUSEKEEPING	-8,018	5,800,840	9.00
10.00	01000	DIETARY	0	3,747,821	10.00
11.00	01100	CAFETERIA	-965,614	1,193,784	11.00
13.00	01300	NURSING ADMINISTRATION	-1,325	3,509,173	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,955,916	14.00
15.00	01500	PHARMACY	-319,290	5,170,016	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-105,456	2,725,756	16.00
17.00	01700	SOCIAL SERVICE	0	465,581	17.00
17.01	01701	STAFF EDUCATION	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	54,990	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	210,423	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	46,752	22.00
23.00	02300	PARAMED ED PROGRAM	-321,084	309,652	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-208,640	35,524,911	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,061,452	31.00
31.01	03101	NEONATAL ICU	-704,900	2,214,171	31.01
40.00	04000	SUBPROVIDER - I PF	0	1,112,915	40.00
41.00	04100	SUBPROVIDER - I RF	0	3,421,365	41.00
43.00	04300	NURSERY	0	898,276	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,857,747	50.00
50.01	05001	ENDOSCOPY	0	2,873,344	50.01
51.00	05100	RECOVERY ROOM	0	1,306,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,167,714	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,140,956	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	-709	1,786,189	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-129,447	1,251,988	55.00
56.00	05600	RADIOISOTOPE	0	1,687,630	56.00
57.00	05700	CT SCAN	-396	1,734,766	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	647,719	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,863,881	59.00
60.00	06000	LABORATORY	-46,925	10,156,797	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-92,967	1,475,415	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,171,714	65.00
66.00	06600	PHYSICAL THERAPY	0	1,672,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,335,285	67.00
68.00	06800	SPEECH PATHOLOGY	0	495,514	68.00
69.00	06900	ELECTROCARDIOLOGY	0	760,892	69.00
69.01	06901	CARDIAC REHAB	-108,859	507,396	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-714	1,126,014	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,044,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,726,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,766,090	73.00
74.00	07400	RENAL DIALYSIS	23	2,106,486	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-47,656	4,949,580	90.00
91.00	09100	EMERGENCY	-32,844	9,674,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,354,292	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,703,816	300,835,487	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	214,467	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,340,320	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet A Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	4,075,099	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	215,294	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	2,703,816	345,680,667	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	854,514	947,655	1.00
	O		854,514	947,655	
B - CLINICAL TRAINING COST					
1.00	PARAMED PROGRAM	23.00	165,783	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	O		165,783	0	
C - SOCIAL WORKERS					
1.00	SOCIAL SERVICE	17.00	465,581	0	1.00
	O		465,581	0	
E - RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	210,423	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	46,752	2.00
	O		0	257,175	
F - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,044,990	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,726,555	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
	O		0	25,771,545	
G - LIGHT DUTY					
1.00	PATIENT TRANSPORTATION	5.06	558	0	1.00
2.00	HOUSEKEEPING	9.00	9,542	0	2.00
3.00	DIETARY	10.00	11,507	0	3.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
5/30/2018 8:22 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	ADULTS & PEDIATRICS	30.00	32,732	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	255	0	5.00
6.00	SUBPROVIDER - IPF	40.00	20,442	0	6.00
7.00	SUBPROVIDER - IRF	41.00	6,213	0	7.00
8.00	OPERATING ROOM	50.00	23,315	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	185	0	9.00
10.00	EMERGENCY	91.00	215	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,771	0	11.00
	0		119,735	0	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,439,235	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	3,439,235	
I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,439,957	1.00
2.00	OPERATION OF PLANT	7.00	0	4,672,851	2.00
	0		0	10,112,808	
J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,740,019	1.00
2.00		0.00	0	0	2.00
	0		0	12,740,019	
K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5.05	0	43,900	1.00
2.00	CLINIC	90.00	0	48,945	2.00
	TOTALS		0	92,845	
L - PSTD RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	350,875	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	0		0	350,875	
M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,242,358	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
	TOTALS		0	13,242,358		
500.00	Grand Total: Increases		1,605,613	66,954,515		500.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
5/30/2018 8:22 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	854,514	947,655	0		1.00
	O		854,514	947,655			
B - CLINICAL TRAINING COST							
1.00	ADULTS & PEDIATRICS	30.00	11,926	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	6,743	0	0		2.00
3.00	OPERATING ROOM	50.00	8,672	0	0		3.00
4.00	ENDOSCOPY	50.01	3,136	0	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	1,810	0	0		5.00
6.00	RESPIRATORY THERAPY	65.00	5,674	0	0		6.00
7.00	EMERGENCY	91.00	127,822	0	0		7.00
	O		165,783	0			
C - SOCIAL WORKERS							
1.00	OTHER A&G	5.05	465,581	0	0		1.00
	O		465,581	0			
E - RESIDENTS							
1.00	EMERGENCY	91.00	0	257,175	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	257,175			
F - MED SUPPLY							
1.00	PURCHASING RECEIVING AND STORES	5.02	0	70,662	0		1.00
2.00	ADMITTING	5.03	0	7	0		2.00
3.00	OTHER A&G	5.05	0	517	0		3.00
4.00	OPERATION OF PLANT	7.00	0	14	0		4.00
5.00	HOUSEKEEPING	9.00	0	2,519	0		5.00
6.00	DIETARY	10.00	0	25	0		6.00
7.00	CAFETERIA	11.00	0	28	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	1,236	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	187,398	0		9.00
10.00	PHARMACY	15.00	0	30,705	0		10.00
11.00	MEDICAL EDUCATION	17.02	0	249	0		11.00
12.00	PARAMEDICAL PROGRAM	23.00	0	340	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	656,975	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	226,633	0		14.00
15.00	NEONATAL ICU	31.01	0	145	0		15.00
16.00	SUBPROVIDER - IPF	40.00	0	5	0		16.00
17.00	SUBPROVIDER - IRF	41.00	0	56,117	0		17.00
18.00	NURSERY	43.00	0	29,581	0		18.00
19.00	OPERATING ROOM	50.00	0	15,129,728	0		19.00
20.00	ENDOSCOPY	50.01	0	343,766	0		20.00
21.00	RECOVERY ROOM	51.00	0	14,406	0		21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15,632	0		22.00
23.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,438	0		23.00
24.00	RADIOLOGY - ULTRASOUND	54.01	0	36,289	0		24.00
25.00	RADIOLOGY-THERAPEUTIC	55.00	0	10,943	0		25.00
26.00	RADIOISOTOPE	56.00	0	329	0		26.00
27.00	CT SCAN	57.00	0	36,582	0		27.00
28.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	274	0		28.00
29.00	CARDIAC CATHETERIZATION	59.00	0	4,824,111	0		29.00
30.00	LABORATORY	60.00	0	1,135	0		30.00
31.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	572	0		31.00
32.00	RESPIRATORY THERAPY	65.00	0	214,747	0		32.00
33.00	PHYSICAL THERAPY	66.00	0	814	0		33.00
34.00	OCCUPATIONAL THERAPY	67.00	0	40	0		34.00
35.00	SPEECH PATHOLOGY	68.00	0	199	0		35.00
36.00	ELECTROCARDIOLOGY	69.00	0	6,238	0		36.00
37.00	CARDIAC REHAB	69.01	0	1,247	0		37.00
38.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,286,474	0		38.00
39.00	DRUGS CHARGED TO PATIENTS	73.00	0	201,709	0		39.00
40.00	RENAL DIALYSIS	74.00	0	2,263	0		40.00
41.00	CLINIC	90.00	0	139,243	0		41.00
42.00	EMERGENCY	91.00	0	174,971	0		42.00
43.00	HOME HEALTH AGENCY	101.00	0	6,262	0		43.00
44.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	57,975	0		44.00
45.00	FAMILY HEALTH/GARY COMM HEALTH	192.02	0	2	0		45.00
	O		0	25,771,545			
G - LIGHT DUTY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	119,735	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
5/30/2018 8:22 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
4.00	0.00	0	0	0	0	4.00	
5.00	0.00	0	0	0	0	5.00	
6.00	0.00	0	0	0	0	6.00	
7.00	0.00	0	0	0	0	7.00	
8.00	0.00	0	0	0	0	8.00	
9.00	0.00	0	0	0	0	9.00	
10.00	0.00	0	0	0	0	10.00	
11.00	0.00	0	0	0	0	11.00	
0		119,735	0				
H - INTEREST EXPENSE							
1.00	OTHER A&G	5.05	0	1,867,996	11	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	118,024	11	2.00	
3.00	RADIOLOGY - ULTRASOUND	54.01	0	59,012	11	3.00	
4.00	CT SCAN	57.00	0	59,012	11	4.00	
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	59,012	11	5.00	
6.00	OTHER NON-REIMBURSABLE	192.01	0	1,276,179	11	6.00	
0			0	3,439,235			
I - CORPORATE EXPENSE							
1.00	OTHER A&G	5.05	0	10,112,808	9	1.00	
2.00		0.00	0	0	0	2.00	
0			0	10,112,808			
J - DRUG EXPENSE							
1.00	PHARMACY	15.00	0	9,692,963	0	1.00	
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,047,056	0	2.00	
0			0	12,740,019			
K - PHYSICIAN RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	92,845	0	1.00	
2.00		0.00	0	0	0	2.00	
0			0	92,845			
L - PSTD RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,570	0	0	1.00	
2.00	DATA PROCESSING	5.01	1,832	0	0	2.00	
3.00	ADMINISTRATIVE	5.03	957	0	0	3.00	
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	7,170	0	0	4.00	
5.00	OTHER A&G	5.05	25,728	0	0	5.00	
6.00	PATIENT TRANSPORTATION	5.06	10,244	0	0	6.00	
7.00	HOUSEKEEPING	9.00	22,530	0	0	7.00	
8.00	DIETARY	10.00	24,339	0	0	8.00	
9.00	CAFETERIA	11.00	3,852	0	0	9.00	
10.00	NURSING ADMINISTRATION	13.00	20,209	0	0	10.00	
11.00	CENTRAL SERVICES & SUPPLY	14.00	1,165	0	0	11.00	
12.00	ADULTS & PEDIATRICS	30.00	58,129	0	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	11,542	0	0	13.00	
14.00	NEONATAL ICU	31.01	6,252	0	0	14.00	
15.00	SUBPROVIDER - IPF	40.00	13,148	0	0	15.00	
16.00	SUBPROVIDER - IRF	41.00	9,361	0	0	16.00	
17.00	OPERATING ROOM	50.00	13,137	0	0	17.00	
18.00	DELIVERY ROOM & LABOR ROOM	52.00	5,500	0	0	18.00	
19.00	RADIOLOGY-DIAGNOSTIC	54.00	10,495	0	0	19.00	
20.00	CT SCAN	57.00	6,080	0	0	20.00	
21.00	CARDIAC CATHETERIZATION	59.00	16,136	0	0	21.00	
22.00	LABORATORY	60.00	11,503	0	0	22.00	
23.00	RESPIRATORY THERAPY	65.00	2,981	0	0	23.00	
24.00	SPEECH PATHOLOGY	68.00	463	0	0	24.00	
25.00	CLINIC	90.00	740	0	0	25.00	
26.00	EMERGENCY	91.00	12,464	0	0	26.00	
27.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	5,858	0	0	27.00	
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	47,490	0	0	28.00	
0			350,875	0			
M - DEPRECIATION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,698	9	1.00	
2.00	DATA PROCESSING	5.01	0	2,405,815	0	2.00	
3.00	PURCHASING RECEIVING AND STORES	5.02	0	3,892	0	3.00	
4.00	ADMINISTRATIVE	5.03	0	64	0	4.00	
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	4,791	0	5.00	
6.00	OTHER A&G	5.05	0	233,278	0	6.00	
7.00	PATIENT TRANSPORTATION	5.06	0	20,989	0	7.00	
8.00	OPERATION OF PLANT	7.00	0	432,858	0	8.00	
9.00	HOUSEKEEPING	9.00	0	32,629	0	9.00	

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
5/30/2018 8:22 am

		Decreases			Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other	6.00	7.00	
	6.00	7.00	8.00	9.00	10.00		
10.00	DIETARY	10.00	0	78,320	0		10.00
11.00	CAFETERIA	11.00	0	2,286	0		11.00
12.00	NURSING ADMINISTRATION	13.00	0	27,211	0		12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	0	223,864	0		13.00
14.00	PHARMACY	15.00	0	134,044	0		14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,284	0		15.00
16.00	PARAMEDICAL PROGRAM	23.00	0	6,616	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	1,322,236	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	504,201	0		18.00
19.00	NEONATAL ICU	31.01	0	22,054	0		19.00
20.00	SUBPROVIDER - IPF	40.00	0	12,656	0		20.00
21.00	SUBPROVIDER - IRF	41.00	0	10,336	0		21.00
22.00	NURSERY	43.00	0	57,346	0		22.00
23.00	OPERATING ROOM	50.00	0	1,386,210	0		23.00
24.00	ENDOSCOPY	50.01	0	381,559	0		24.00
25.00	RECOVERY ROOM	51.00	0	2,719	0		25.00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	194,665	0		26.00
27.00	RADIOLOGY-DIAGNOSTIC	54.00	0	588,272	0		27.00
28.00	RADIOLOGY - ULTRASOUND	54.01	0	411,781	0		28.00
29.00	RADIOLOGY-THERAPEUTIC	55.00	0	373,427	0		29.00
30.00	RADIOISOTOPE	56.00	0	125,401	0		30.00
31.00	CT SCAN	57.00	0	432,272	0		31.00
32.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	523,909	0		32.00
33.00	CARDIAC CATHETERIZATION	59.00	0	868,343	0		33.00
34.00	LABORATORY	60.00	0	39,653	0		34.00
35.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	4,098	0		35.00
36.00	RESPIRATORY THERAPY	65.00	0	119,092	0		36.00
37.00	PHYSICAL THERAPY	66.00	0	1,401	0		37.00
38.00	OCCUPATIONAL THERAPY	67.00	0	424	0		38.00
39.00	SPEECH PATHOLOGY	68.00	0	4,010	0		39.00
40.00	ELECTROCARDIOLOGY	69.00	0	112,217	0		40.00
41.00	CARDIAC REHAB	69.01	0	116,010	0		41.00
42.00	ELECTROENCEPHALOGRAPHY	70.00	0	51,889	0		42.00
43.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,875	0		43.00
44.00	CLINIC	90.00	0	165,897	0		44.00
45.00	EMERGENCY	91.00	0	401,889	0		45.00
46.00	HOME HEALTH AGENCY	101.00	0	567	0		46.00
47.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	5,376	0		47.00
48.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	703,460	0		48.00
49.00	OTHER NON-REIMBURSABLE	192.01	0	665,474	0		49.00
	TOTALS		0	13,242,358			
500.00	Grand Total: Decreases		1,956,488	66,603,640			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2018 8:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,445,499	928,175	0	928,175	0	1.00
2.00	Land Improvements	6,459,679	192,448	0	192,448	0	2.00
3.00	Buildings and Fixtures	274,400,272	7,197,192	0	7,197,192	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	192,338,088	7,792,023	0	7,792,023	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	477,643,538	16,109,838	0	16,109,838	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	477,643,538	16,109,838	0	16,109,838	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,373,674	0				1.00
2.00	Land Improvements	6,652,127	0				2.00
3.00	Buildings and Fixtures	281,597,464	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	200,130,111	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	493,753,376	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	493,753,376	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description	SUMMARY OF CAPITAL					
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

Cost Center Description	SUMMARY OF CAPITAL		
	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
	14.00	15.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	493,753,376	0	493,753,376	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	493,753,376	0	493,753,376	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	18,978,515	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	18,978,515	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,276,180	0	0	0	20,254,695	1.00
3.00	Total (sum of lines 1-2)	1,276,180	0	0	0	20,254,695	3.00

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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,163,055	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	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	-1,105,262			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	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-965,614	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-105,456	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	296,200	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 DATA PROCESSING OTHER INCOME	B	-177,723		DATA PROCESSING	5.01	33.00
33.01 CASH, A/R, COLLECTIONS OTHER INCOME	B	-61,481		CASHIERING/ACCOUNTS RECEIVABLE	5.04	33.01
33.02 A&G OTHER INCOME	B	-342,713		OTHER A&G	5.05	33.02
34.00 ENVIRONMENTAL SERVICES OTHER INCOME	B	-8,018		HOUSEKEEPING	9.00	34.00
35.00 NURSING ADMIN OTHER INCOME	B	-1,325		NURSING ADMINISTRATION	13.00	35.00
36.00 RX PROGRAM	A	-319,290		PHARMACY	15.00	36.00
37.00 PARAMED ED PROGRAM OTHER INCOME	B	-321,084		PARAMED ED PROGRAM	23.00	37.00
38.00 ADULTS & PEDI OTHER INCOME	B	-16,890		ADULTS & PEDIATRICS	30.00	38.00
40.00 RADIOLOGY - THERAPEUTIC	B	-1,715		RADIOLOGY-THERAPEUTIC	55.00	40.00
40.01 LAB OTHER INCOME	B	-46,925		LABORATORY	60.00	40.01
41.00 BLOOD OTHER INCOME	B	-92,967		WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	41.00
42.00 CARDIAC REHAB OTHER INCOME	B	-108,859		CARDIAC REHAB	69.01	42.00
43.00 ELECTROCEPHALOGRAPHY OTHER INCOME	B	-714		ELECTROENCEPHALOGRAPHY	70.00	43.00
44.00 RENAL DIALYSIS	B	23		RENAL DIALYSIS	74.00	44.00
44.01 CLINIC OTHER INCOME	B	-725		CLINIC	90.00	44.01
45.00 LOBBYING EXPENSE	A	-68,940		OTHER A&G	5.05	45.00
46.00 DUES/LOBBYING	A	-92,571		OTHER A&G	5.05	46.00
46.01 PENSION ADJUSTMENT	A	8,408,920		EMPLOYEE BENEFITS DEPARTMENT	4.00	46.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,703,816				50.00

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

(2) Basis for adjustment (see instructions).

- A. Costs - if cost, including applicable overhead, can be determined.
- B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0002

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2018 8:22 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	191,750	191,750	0	0	0	1.00
2.00	31.01	NEONATAL ICU	704,900	704,900	0	0	0	2.00
3.00	54.01	RADIOLOGY - ULTRASOUND	709	709	0	0	0	3.00
4.00	57.00	CT SCAN	396	396	0	0	0	4.00
5.00	90.00	CLINIC	99,250	16,600	82,650	197,500	551	5.00
6.00	91.00	EMERGENCY	89,350	17,800	71,550	246,400	477	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	190,478	118,478	72,000	271,900	480	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,276,833	1,050,633	226,200		1,508	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.01	NEONATAL ICU	0	0	0	0	0	2.00
3.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	0	0	3.00
4.00	57.00	CT SCAN	0	0	0	0	0	4.00
5.00	90.00	CLINIC	52,319	2,616	0	0	0	5.00
6.00	91.00	EMERGENCY	56,506	2,825	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	62,746	3,137	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			171,571	8,578	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	191,750	1.00
2.00	31.01	NEONATAL ICU	0	0	0	704,900	2.00
3.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	709	3.00
4.00	57.00	CT SCAN	0	0	0	396	4.00
5.00	90.00	CLINIC	0	52,319	30,331	46,931	5.00
6.00	91.00	EMERGENCY	0	56,506	15,044	32,844	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	62,746	9,254	127,732	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	171,571	54,629	1,105,262	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES		
		RELATED COSTS BLDG & FIXT					
	0	1.00	4.00	5.01	5.02		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	20,254,695	20,254,695				1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	35,881,867	84,832	35,966,699			4.00	
5.01 00550 DATA PROCESSING	10,633,823	132,002	968,979	11,734,804		5.01	
5.02 00560 PURCHASING RECEIVING AND STORES	3,351,236	105,314	241,098	0	3,697,648	5.02	
5.03 00570 ADMITTING	2,418,852	139,572	472,930	0	4,669	5.03	
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	4,408,258	440,189	507,643	0	1,985	5.04	
5.05 00590 OTHER A&G	18,975,796	1,430,321	2,662,556	11,734,804	5,522	5.05	
5.06 00592 PATIENT TRANSPORTATION	627,975	0	138,718	0	347	5.06	
7.00 00700 OPERATION OF PLANT	18,862,772	4,299,465	928,256	0	49,190	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	1,353,425	256,033	0	0	19	8.00	
9.00 00900 HOUSEKEEPING	5,800,840	296,394	1,090,145	0	39,701	9.00	
10.00 01000 DIETARY	3,747,821	270,727	498,024	0	34,267	10.00	
11.00 01100 CAFETERIA	1,193,784	189,270	281,746	0	35	11.00	
13.00 01300 NURSING ADMINISTRATION	3,509,173	91,209	698,477	0	2,754	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	1,955,916	514,837	125,476	0	33,081	14.00	
15.00 01500 PHARMACY	5,170,016	272,292	0	0	14,305	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	2,725,756	162,410	486,172	0	758	16.00	
17.00 01700 SOCIAL SERVICE	465,581	23,398	111,685	0	0	17.00	
17.01 01701 STAFF EDUCATION	0	160,112	0	0	0	17.01	
17.02 01702 MEDICAL EDUCATION	54,990	5,372	4,127	0	52	17.02	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	210,423	0	0	0	0	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	46,752	64,163	0	0	0	22.00	
23.00 02300 PARAMED ED PROGRAM	309,652	48,319	135,374	0	829	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	35,524,911	4,498,953	7,259,614	0	182,979	30.00	
31.00 03100 INTENSIVE CARE UNIT	8,061,452	285,320	1,603,673	0	70,722	31.00	
31.01 03101 NEONATAL ICU	2,214,171	32,433	489,632	0	500	31.01	
40.00 04000 SUBPROVIDER - I PF	1,112,915	57,053	246,284	0	244	40.00	
41.00 04100 SUBPROVIDER - I RF	3,421,365	448,764	713,345	0	10,062	41.00	
43.00 04300 NURSERY	898,276	350,818	166,685	0	11,640	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	6,857,747	856,750	1,062,562	0	68,728	50.00	
50.01 05001 ENDOSCOPY	2,873,344	0	295,461	0	65,421	50.01	
51.00 05100 RECOVERY ROOM	1,306,587	208,934	280,297	0	3,731	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,167,714	100,589	677,473	0	10,589	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,140,956	762,122	579,682	0	13,751	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	1,786,189	72,594	336,490	0	13,865	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	1,251,988	193,694	111,189	0	2,677	55.00	
56.00 05600 RADIOISOTOPE	1,687,630	129,891	143,631	0	86,797	56.00	
57.00 05700 CT SCAN	1,734,766	122,996	261,282	0	25,579	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	647,719	60,399	106,090	0	8,285	58.00	
59.00 05900 CARDIAC CATHETERIZATION	2,863,881	120,554	490,052	0	71,375	59.00	
60.00 06000 LABORATORY	10,156,797	337,805	846,773	0	265,975	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,475,415	5,530	283,203	0	25,194	62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	3,171,714	111,548	578,668	0	46,964	65.00	
66.00 06600 PHYSICAL THERAPY	1,672,961	176,242	370,493	0	1,081	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,335,285	151,465	294,746	0	1,219	67.00	
68.00 06800 SPEECH PATHOLOGY	495,514	25,797	100,473	0	454	68.00	
69.00 06900 ELECTROCARDIOLOGY	760,892	0	154,626	0	1,509	69.00	
69.01 06901 CARDIAC REHAB	507,396	0	94,773	0	387	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	1,126,014	0	211,873	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,044,990	0	0	0	1,049,817	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13,726,555	0	0	0	1,196,362	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	13,766,090	23,872	92,288	0	49,913	73.00	
74.00 07400 RENAL DIALYSIS	2,106,486	62,956	0	0	2,408	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	4,949,580	1,094,239	691,807	0	8,850	90.00	
91.00 09100 EMERGENCY	9,674,492	388,724	1,700,318	0	156,314	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	2,354,292	0	482,835	0	7,491	101.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	300,835,487	19,666,273	30,077,724	11,734,804	3,648,397	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES		
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	214,467	25,869	9,531	0	14,583	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,340,320	383,668	5,222,757	0	33,912	192.00
192.01	19201	OTHER NON-REIMBURSABLE	4,075,099	49,655	617,745	0	756	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	215,294	129,230	38,942	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	345,680,667	20,254,695	35,966,699	11,734,804	3,697,648	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description			ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMINISTRATIVE	3,036,023					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	5,358,075				5.04
5.05	00590	OTHER A&G	0	0	34,808,999	34,808,999		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	767,040	85,887	852,927	5.06
7.00	00700	OPERATION OF PLANT	0	0	24,139,683	2,702,969	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,609,477	180,216	0	8.00
9.00	00900	HOUSEKEEPING	0	0	7,227,080	809,231	0	9.00
10.00	01000	DIETARY	0	0	4,550,839	509,567	0	10.00
11.00	01100	CAFETERIA	0	0	1,664,835	186,415	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,301,613	481,660	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,629,310	294,409	0	14.00
15.00	01500	PHARMACY	0	0	5,456,613	610,988	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,375,096	377,916	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	600,664	67,258	0	17.00
17.01	01701	STAFF EDUCATION	0	0	160,112	17,928	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	64,541	7,227	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	210,423	23,561	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	110,915	12,419	0	22.00
23.00	02300	PARAMED PROGRAM	0	0	494,174	55,334	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	246,872	435,697	48,149,026	5,391,418	349,795	30.00
31.00	03100	INTENSIVE CARE UNIT	43,638	77,016	10,141,821	1,135,600	4,855	31.00
31.01	03101	NEONATAL ICU	14,119	24,918	2,775,773	310,809	0	31.01
40.00	04000	SUBPROVIDER - I/PF	8,615	15,205	1,440,316	161,275	368	40.00
41.00	04100	SUBPROVIDER - I/RF	19,680	34,732	4,647,948	520,440	9,692	41.00
43.00	04300	NURSERY	5,184	9,149	1,441,752	161,436	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	414,492	731,412	9,991,691	1,118,790	70	50.00
50.01	05001	ENDOSCOPY	48,455	85,516	3,368,197	377,144	21,154	50.01
51.00	05100	RECOVERY ROOM	26,638	47,012	1,873,199	209,746	18	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,346	23,554	3,993,265	447,134	6,607	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,930	162,244	5,750,685	643,916	85,280	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	41,210	72,730	2,323,078	260,120	88,821	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	34,106	60,193	1,653,847	185,185	5,854	55.00
56.00	05600	RADIOISOTOPE	37,856	66,811	2,152,616	241,033	45,812	56.00
57.00	05700	CT SCAN	273,901	483,401	2,901,925	324,934	135,457	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70,449	124,333	1,017,275	113,906	50,281	58.00
59.00	05900	CARDIAC CATHETERIZATION	180,426	318,428	4,044,716	452,895	31,073	59.00
60.00	06000	LABORATORY	357,209	630,428	12,594,987	1,410,286	18	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			0			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,119	39,038	1,850,499	207,204	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	100,592	177,532	4,187,018	468,829	736	65.00
66.00	06600	PHYSICAL THERAPY	18,964	33,469	2,273,210	254,536	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,427	27,227	1,825,369	204,390	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,490	9,690	637,418	71,373	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,086	90,159	1,058,272	118,497	3,593	69.00
69.01	06901	CARDIAC REHAB	2,297	4,054	608,907	68,181	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	57,824	102,051	1,497,762	167,707	7,045	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,621	218,175	13,436,603	1,504,523	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,363	155,950	15,167,230	1,698,305	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,580	671,674	14,984,417	1,677,835	0	73.00
74.00	07400	RENAL DIALYSIS	21,076	37,197	2,230,123	249,711	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	55,427	97,821	6,897,724	772,352	684	90.00
91.00	09100	EMERGENCY	156,715	276,582	12,353,145	1,383,206	5,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	8,316	14,677	2,867,611	321,092	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,036,023	5,358,075	294,308,839	29,056,793	852,909	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	264,450	29,611	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	45,980,657	5,148,546	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description			ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	4,743,255	531,112	18	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	383,466	42,937	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,036,023	5,358,075	345,680,667	34,808,999	852,927	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT	26,842,652					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	504,485	2,294,178				8.00
9.00	00900	HOUSEKEEPING	584,013	0	8,620,324			9.00
10.00	01000	DIETARY	533,438	0	178,550	5,772,394		10.00
11.00	01100	CAFETERIA	372,936	0	124,828	0	2,349,014	11.00
13.00	01300	NURSING ADMINISTRATION	179,718	0	60,155	0	55,615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,014,431	25,006	339,546	0	23,795	14.00
15.00	01500	PHARMACY	536,522	14	179,583	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	320,012	0	107,113	0	73,182	16.00
17.00	01700	SOCIAL SERVICE	46,104	0	15,432	0	13,188	17.00
17.01	01701	STAFF EDUCATION	315,483	0	105,597	0	0	17.01
17.02	01702	MEDICAL EDUCATION	10,585	0	3,543	0	269	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	126,425	0	42,317	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	95,208	0	31,868	0	17,961	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,864,693	1,073,201	2,967,153	4,027,977	833,273	30.00
31.00	03100	INTENSIVE CARE UNIT	562,192	56,814	188,175	712,357	148,002	31.00
31.01	03101	NEONATAL ICU	63,906	50,150	21,390	0	40,347	31.01
40.00	04000	SUBPROVIDER - IPF	112,416	0	37,627	0	24,008	40.00
41.00	04100	SUBPROVIDER - IRF	884,242	0	295,970	514,481	79,075	41.00
43.00	04300	NURSERY	691,250	46,619	231,372	0	15,542	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,688,134	225,989	565,045	0	114,316	50.00
50.01	05001	ENDOSCOPY	0	25,336	0	33	29,096	50.01
51.00	05100	RECOVERY ROOM	411,682	59,156	137,796	0	23,823	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	198,199	50,539	66,340	204,727	66,444	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,501,680	75,144	502,636	0	69,453	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	143,039	12,750	47,877	0	29,092	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	381,654	3,407	127,745	0	10,513	55.00
56.00	05600	RADIOISOTOPE	255,936	27,569	85,666	0	12,010	56.00
57.00	05700	CT SCAN	242,351	17,319	81,119	0	27,352	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	119,010	6,924	39,835	0	10,220	58.00
59.00	05900	CARDIAC CATHETERIZATION	237,539	49,468	79,508	62,790	42,032	59.00
60.00	06000	LABORATORY	665,608	0	222,790	0	96,889	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,896	0	3,647	0	53,504	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	219,794	3,328	73,569	0	63,130	65.00
66.00	06600	PHYSICAL THERAPY	347,266	27,296	116,236	0	35,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	298,445	0	99,894	0	26,213	67.00
68.00	06800	SPEECH PATHOLOGY	50,831	0	17,014	17,078	8,225	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,975	0	0	18,589	69.00
69.01	06901	CARDIAC REHAB	0	7,669	0	0	10,323	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	279	20,488	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,038	0	15,744	0	0	73.00
74.00	07400	RENAL DIALYSIS	124,048	104,129	41,521	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,156,081	73,715	721,674	0	63,290	90.00
91.00	09100	EMERGENCY	765,939	241,475	256,372	232,672	184,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,683,229	2,275,992	8,232,247	5,772,394	2,346,600	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,972	0	17,061	0	2,414	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	755,977	18,186	253,037	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	97,840	0	32,749	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
192.02	19202 FAMILY HEALTH/GARY COMM HEALTH	254,634	0	85,230	0	0	192.02
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	26,842,652	2,294,178	8,620,324	5,772,394	2,349,014	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,078,761					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,326,497				14.00
15.00	01500	PHARMACY	0	0	6,783,720			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,253,319		16.00
17.00	01700	SOCIAL SERVICE	42,058	0	0	0	784,704	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	57,276	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,657,298	0	92	345,799	605,427	30.00
31.00	03100	INTENSIVE CARE UNIT	471,980	0	0	61,125	0	31.00
31.01	03101	NEONATAL ICU	128,667	0	0	19,777	0	31.01
40.00	04000	SUBPROVIDER - I PF	76,563	0	0	12,067	0	40.00
41.00	04100	SUBPROVIDER - I RF	252,171	0	0	27,566	134,213	41.00
43.00	04300	NURSERY	49,563	0	0	7,261	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	364,553	0	0	581,283	0	50.00
50.01	05001	ENDOSCOPY	92,786	0	0	67,871	0	50.01
51.00	05100	RECOVERY ROOM	75,971	0	0	37,312	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	211,890	0	0	18,694	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	128,768	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	57,723	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	47,773	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	53,026	0	56.00
57.00	05700	CT SCAN	0	0	0	383,660	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	98,679	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	252,726	0	59.00
60.00	06000	LABORATORY	0	0	749,470	500,351	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	30,983	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	140,902	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,563	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	21,609	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,690	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	71,557	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	3,218	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	80,995	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,022,101	0	173,159	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,304,396	0	123,772	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,876,939	533,087	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	29,522	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	77,638	0	90.00
91.00	09100	EMERGENCY	597,985	0	0	219,514	45,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	4,984	11,649	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,078,761	4,326,497	6,631,485	4,253,319	784,704	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	152,235	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0002			Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
			13.00	14.00	15.00	16.00	17.00		
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0		
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0		
193.00	19300	NONPAID WORKERS	0	0	0	0	0		
200.00		Cross Foot Adjustments							
201.00		Negative Cost Centers	0	0	0	0	0		
202.00		TOTAL (sum lines 118 through 201)	5,078,761	4,326,497	6,783,720	4,253,319	784,704		

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00		
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00			
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.01 00550 DATA PROCESSING						5.01	
5.02 00560 PURCHASING RECEIVING AND STORES						5.02	
5.03 00570 ADMITTING						5.03	
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04	
5.05 00590 OTHER A&G						5.05	
5.06 00592 PATIENT TRANSPORTATION						5.06	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
13.00 01300 NURSING ADMINISTRATION						13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00	
15.00 01500 PHARMACY						15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00	
17.00 01700 SOCIAL SERVICE						17.00	
17.01 01701 STAFF EDUCATION	599,120					17.01	
17.02 01702 MEDICAL EDUCATION	0	86,165				17.02	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	233,984			21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	292,076		22.00	
23.00 02300 PARAMED ED PROGRAM	380	0	0	0	752,201	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	293,304	0	0	0	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	56,663	0	0	0	0	31.00	
31.01 03101 NEONATAL ICU	18,246	0	0	0	0	31.01	
40.00 04000 SUBPROVIDER - IPF	6,245	0	0	0	0	40.00	
41.00 04100 SUBPROVIDER - IRF	33,667	0	0	0	0	41.00	
43.00 04300 NURSERY	1,375	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	31,098	0	0	0	0	50.00	
50.01 05001 ENDOSCOPY	1,718	0	0	0	0	50.01	
51.00 05100 RECOVERY ROOM	5,907	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	21,514	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	8,630	0	0	0	0	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	6,185	0	0	0	0	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	2,125	0	0	0	0	55.00	
56.00 05600 RADIO SOTOPE	514	0	0	0	0	56.00	
57.00 05700 CT SCAN	2,333	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	648	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	8,074	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,431	0	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	139	0	0	0	0	62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	7,130	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	167	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	389	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	245	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	1,819	0	0	0	0	69.00	
69.01 06901 CARDIAC REHAB	102	0	0	0	0	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	2,042	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	1,991	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	2,019	0	0	0	0	90.00	
91.00 09100 EMERGENCY	67,140	86,165	233,984	292,076	752,201	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	8,005	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	591,245	86,165	233,984	292,076	752,201	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7,875	0	0	0	0	192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	599,120	86,165	233,984	292,076	752,201	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	75,558,456	0	75,558,456	30.00
31.00	03100	13,539,584	0	13,539,584	31.00
31.01	03101	3,429,065	0	3,429,065	31.01
40.00	04000	1,870,885	0	1,870,885	40.00
41.00	04100	7,399,465	0	7,399,465	41.00
43.00	04300	2,646,170	0	2,646,170	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	14,680,969	0	14,680,969	50.00
50.01	05001	3,983,335	0	3,983,335	50.01
51.00	05100	2,834,610	0	2,834,610	51.00
52.00	05200	5,285,353	0	5,285,353	52.00
53.00	05300	0	0	0	53.00
54.00	05400	8,766,192	0	8,766,192	54.00
54.01	05401	2,968,685	0	2,968,685	54.01
55.00	05500	2,418,103	0	2,418,103	55.00
56.00	05600	2,874,182	0	2,874,182	56.00
57.00	05700	4,116,450	0	4,116,450	57.00
58.00	05800	1,456,778	0	1,456,778	58.00
59.00	05900	5,260,821	0	5,260,821	59.00
60.00	06000	16,241,830	0	16,241,830	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	2,156,872	0	2,156,872	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	5,164,436	0	5,164,436	65.00
66.00	06600	3,080,426	0	3,080,426	66.00
67.00	06700	2,476,309	0	2,476,309	67.00
68.00	06800	809,874	0	809,874	68.00
69.00	06900	1,285,302	0	1,285,302	69.00
69.01	06901	698,400	0	698,400	69.01
70.00	07000	1,776,318	0	1,776,318	70.00
71.00	07100	17,136,386	0	17,136,386	71.00
72.00	07200	19,301,610	0	19,301,610	72.00
73.00	07300	23,137,051	0	23,137,051	73.00
74.00	07400	2,779,054	0	2,779,054	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	10,765,177	0	10,765,177	90.00
91.00	09100	17,716,916	-526,060	17,190,856	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	3,213,341	0	3,213,341	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		286,828,405	-526,060	286,302,345	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	364,508	0	364,508	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,316,513	0	52,316,513	192.00
192.01	19201	OTHER NON-REIMBURSABLE	5,404,974	0	5,404,974	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	766,267	0	766,267	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	345,680,667	-526,060	345,154,607	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT					
		0	1.00				
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	84,832	84,832	84,832	4.00
5.01	00550	DATA PROCESSING	0	132,002	132,002	2,286	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	105,314	105,314	569	5.02
5.03	00570	ADMINISTRATIVE	0	139,572	139,572	1,116	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	440,189	440,189	1,198	5.04
5.05	00590	OTHER A&G	0	1,430,321	1,430,321	6,282	5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	0	327	5.06
7.00	00700	OPERATION OF PLANT	0	4,299,465	4,299,465	2,190	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	256,033	256,033	0	8.00
9.00	00900	HOUSEKEEPING	0	296,394	296,394	2,572	9.00
10.00	01000	DIETARY	0	270,727	270,727	1,175	10.00
11.00	01100	CAFETERIA	0	189,270	189,270	665	11.00
13.00	01300	NURSING ADMINISTRATION	0	91,209	91,209	1,648	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	514,837	514,837	296	14.00
15.00	01500	PHARMACY	0	272,292	272,292	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	162,410	162,410	1,147	16.00
17.00	01700	SOCIAL SERVICE	0	23,398	23,398	264	17.00
17.01	01701	STAFF EDUCATION	0	160,112	160,112	0	17.01
17.02	01702	MEDICAL EDUCATION	0	5,372	5,372	10	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	64,163	64,163	0	22.00
23.00	02300	PARAMED PROGRAM	0	48,319	48,319	319	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,498,953	4,498,953	17,102	30.00
31.00	03100	INTENSIVE CARE UNIT	0	285,320	285,320	3,784	31.00
31.01	03101	NEONATAL ICU	0	32,433	32,433	1,155	31.01
40.00	04000	SUBPROVIDER - IPF	0	57,053	57,053	581	40.00
41.00	04100	SUBPROVIDER - IRF	0	448,764	448,764	1,683	41.00
43.00	04300	NURSERY	0	350,818	350,818	393	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	856,750	856,750	2,507	50.00
50.01	05001	ENDOSCOPY	0	0	0	697	50.01
51.00	05100	RECOVERY ROOM	0	208,934	208,934	661	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	100,589	100,589	1,598	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	762,122	762,122	1,368	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	72,594	72,594	794	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	193,694	193,694	262	55.00
56.00	05600	RADIOISOTOPE	0	129,891	129,891	339	56.00
57.00	05700	CT SCAN	0	122,996	122,996	616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	60,399	60,399	250	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	120,554	120,554	1,156	59.00
60.00	06000	LABORATORY	0	337,805	337,805	1,998	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,530	5,530	668	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	111,548	111,548	1,365	65.00
66.00	06600	PHYSICAL THERAPY	0	176,242	176,242	874	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	151,465	151,465	695	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,797	25,797	237	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	365	69.00
69.01	06901	CARDIAC REHAB	0	0	0	224	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	500	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,872	23,872	218	73.00
74.00	07400	RENAL DIALYSIS	0	62,956	62,956	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,094,239	1,094,239	1,632	90.00
91.00	09100	EMERGENCY	0	388,724	388,724	4,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,139	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,666,273	19,666,273	70,937	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING		
			BLDG & FIXT					
	0		1.00	2A	4.00	5.01		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,869	25,869	22	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	383,668	383,668	12,323	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	49,655	49,655	1,458	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	129,230	129,230	92	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	20,254,695	20,254,695	84,832	134,288	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	105,883					5.02
5.03	00570	ADMITTING	134	140,822				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	57		441,444			5.04
5.05	00590	OTHER A&G	158	0	0	1,571,049		5.05
5.06	00592	PATIENT TRANSPORTATION	10	0	0	3,877	4,214	5.06
7.00	00700	OPERATION OF PLANT	1,409	0	0	122,002	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	0	8,134	0	8.00
9.00	00900	HOUSEKEEPING	1,137	0	0	36,526	0	9.00
10.00	01000	DIETARY	981	0	0	23,000	0	10.00
11.00	01100	CAFETERIA	1	0	0	8,414	0	11.00
13.00	01300	NURSING ADMINISTRATION	79	0	0	21,740	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	947	0	0	13,289	0	14.00
15.00	01500	PHARMACY	410	0	0	27,578	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22	0	0	17,058	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	3,036	0	17.00
17.01	01701	STAFF EDUCATION	0	0	0	809	0	17.01
17.02	01702	MEDICAL EDUCATION	2	0	0	326	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,063	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	561	0	22.00
23.00	02300	PARAMED PROGRAM	24	0	0	2,498	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,240	11,411	35,919	243,247	1,728	30.00
31.00	03100	INTENSIVE CARE UNIT	2,025	2,017	6,349	51,257	24	31.00
31.01	03101	NEONATAL ICU	14	653	2,054	14,029	0	31.01
40.00	04000	SUBPROVIDER - IPF	7	398	1,253	7,279	2	40.00
41.00	04100	SUBPROVIDER - IRF	288	910	2,863	23,491	48	41.00
43.00	04300	NURSERY	333	240	754	7,287	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,968	19,649	60,016	50,498	0	50.00
50.01	05001	ENDOSCOPY	1,874	2,240	7,050	17,023	105	50.01
51.00	05100	RECOVERY ROOM	107	1,231	3,876	9,467	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303	617	1,942	20,182	33	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394	4,249	13,376	29,064	421	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	397	1,905	5,996	11,741	439	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	77	1,576	4,962	8,359	29	55.00
56.00	05600	RADIOISOTOPE	2,486	1,750	5,508	10,879	226	56.00
57.00	05700	CT SCAN	733	12,660	39,852	14,666	669	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	237	3,256	10,250	5,141	248	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,044	8,340	26,252	20,442	154	59.00
60.00	06000	LABORATORY	7,617	16,511	51,973	63,655	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	721	1,022	3,218	9,352	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,345	4,650	14,636	21,161	4	65.00
66.00	06600	PHYSICAL THERAPY	31	877	2,759	11,489	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	35	713	2,245	9,225	0	67.00
68.00	06800	SPEECH PATHOLOGY	13	254	799	3,222	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43	2,361	7,433	5,349	18	69.00
69.01	06901	CARDIAC REHAB	11	106	334	3,077	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,673	8,413	7,570	35	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,064	5,714	17,987	67,909	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,251	4,084	12,857	76,655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,429	17,591	55,374	75,731	0	73.00
74.00	07400	RENAL DIALYSIS	69	974	3,067	11,271	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	253	2,562	8,065	34,861	3	90.00
91.00	09100	EMERGENCY	4,476	7,244	22,802	62,433	28	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	215	384	1,210	14,493	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,472	140,822	441,444	1,311,416	4,214	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	418	0	0	1,337	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	971	0	0	232,386	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
192.01	19201	OTHER NON-REIMBURSABLE	22	0	0	23,972	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	1,938	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	105,883	140,822	441,444	1,571,049	4,214	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00570	ADMITTING					5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04	
5.05	00590	OTHER A&G					5.05	
5.06	00592	PATIENT TRANSPORTATION					5.06	
7.00	00700	OPERATION OF PLANT	4,425,066				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	83,165	347,333			8.00	
9.00	00900	HOUSEKEEPING	96,276	0	432,905		9.00	
10.00	01000	DIETARY	87,938	0	8,967	392,788	10.00	
11.00	01100	CAFETERIA	61,479	0	6,269	0	266,098	11.00
13.00	01300	NURSING ADMINISTRATION	29,627	0	3,021	0	6,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	167,231	3,786	17,052	0	2,696	14.00
15.00	01500	PHARMACY	88,447	2	9,018	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,755	0	5,379	0	8,290	16.00
17.00	01700	SOCIAL SERVICE	7,600	0	775	0	1,494	17.00
17.01	01701	STAFF EDUCATION	52,008	0	5,303	0	0	17.01
17.02	01702	MEDICAL EDUCATION	1,745	0	178	0	31	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	20,841	0	2,125	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	15,695	0	1,600	0	2,035	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,461,363	162,480	149,008	274,088	94,388	30.00
31.00	03100	INTENSIVE CARE UNIT	92,679	8,601	9,450	48,473	16,766	31.00
31.01	03101	NEONATAL ICU	10,535	7,593	1,074	0	4,571	31.01
40.00	04000	SUBPROVIDER - IPF	18,532	0	1,890	0	2,720	40.00
41.00	04100	SUBPROVIDER - IRF	145,769	0	14,863	35,008	8,958	41.00
43.00	04300	NURSERY	113,954	7,058	11,619	0	1,761	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	278,292	34,214	28,376	0	12,950	50.00
50.01	05001	ENDOSCOPY	0	3,836	0	2	3,296	50.01
51.00	05100	RECOVERY ROOM	67,867	8,956	6,920	0	2,699	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,674	7,652	3,332	13,931	7,527	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,555	11,377	25,242	0	7,868	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	23,580	1,930	2,404	0	3,296	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	62,916	516	6,415	0	1,191	55.00
56.00	05600	RADIOISOTOPE	42,192	4,174	4,302	0	1,361	56.00
57.00	05700	CT SCAN	39,952	2,622	4,074	0	3,099	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	19,619	1,048	2,000	0	1,158	58.00
59.00	05900	CARDIAC CATHETERIZATION	39,159	7,489	3,993	4,273	4,761	59.00
60.00	06000	LABORATORY	109,727	0	11,188	0	10,976	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,796	0	183	0	6,061	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	36,233	504	3,695	0	7,151	65.00
66.00	06600	PHYSICAL THERAPY	57,248	4,133	5,837	0	3,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,199	0	5,017	0	2,969	67.00
68.00	06800	SPEECH PATHOLOGY	8,380	0	854	1,162	932	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,964	0	0	2,106	69.00
69.01	06901	CARDIAC REHAB	0	1,161	0	0	1,169	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	19	2,321	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,754	0	791	0	0	73.00
74.00	07400	RENAL DIALYSIS	20,450	15,765	2,085	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	355,434	11,160	36,242	0	7,170	90.00
91.00	09100	EMERGENCY	126,267	36,559	12,875	15,832	20,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,233,933	344,580	413,416	392,788	265,825	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,403	0	857	0	273	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	124,624	2,753	12,707	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	16,129	0	1,645	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am		
Cost Center Description		OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 11.00
192.02	19202 FAMILY HEALTH/GARY COMM HEALTH	41,977	0	4,280	0	0
193.00	19300 NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	4,425,066	347,333	432,905	392,788	266,098

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am			
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	153,624					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	720,134				14.00
15.00	01500	PHARMACY	0	0	397,747			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	247,061		16.00
17.00	01700	SOCIAL SERVICE	1,272	0	0	0	37,839	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	1,733	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	80,378	0	5	20,043	29,194	30.00
31.00	03100	INTENSIVE CARE UNIT	14,277	0	0	3,543	0	31.00
31.01	03101	NEONATAL ICU	3,892	0	0	1,146	0	31.01
40.00	04000	SUBPROVIDER - I/PF	2,316	0	0	699	0	40.00
41.00	04100	SUBPROVIDER - I/RF	7,628	0	0	1,598	6,472	41.00
43.00	04300	NURSERY	1,499	0	0	421	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,027	0	0	34,216	0	50.00
50.01	05001	ENDOSCOPY	2,807	0	0	3,934	0	50.01
51.00	05100	RECOVERY ROOM	2,298	0	0	2,163	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,409	0	0	1,084	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,464	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	3,346	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,769	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	3,074	0	56.00
57.00	05700	CT SCAN	0	0	0	22,238	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,720	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,649	0	59.00
60.00	06000	LABORATORY	0	0	43,943	29,002	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,796	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,167	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,540	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,253	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	446	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,148	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	187	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,695	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	336,573	0	10,037	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	383,561	0	7,174	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	344,581	30,899	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,711	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,500	0	90.00
91.00	09100	EMERGENCY	18,088	0	0	12,724	2,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	292	675	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,624	720,134	388,821	247,061	37,839	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,926	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	153,624	720,134	397,747	247,061	37,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED PROGRAM	
	17.01	17.02	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER A&G					5.05
5.06 00592	PATIENT TRANSPORTATION					5.06
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01701	STAFF EDUCATION	218,232				17.01
17.02 01702	MEDICAL EDUCATION	0	7,664			17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,063		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	87,690	22.00
23.00 02300	PARAMED PROGRAM	138	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	106,837	0			30.00
31.00 03100	INTENSIVE CARE UNIT	20,640	0			31.00
31.01 03101	NEONATAL ICU	6,646	0			31.01
40.00 04000	SUBPROVIDER - I PF	2,275	0			40.00
41.00 04100	SUBPROVIDER - I RF	12,263	0			41.00
43.00 04300	NURSERY	501	0			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,327	0			50.00
50.01 05001	ENDOSCOPY	626	0			50.01
51.00 05100	RECOVERY ROOM	2,152	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,837	0			52.00
53.00 05300	ANESTHESIOLOGY	0	0			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,143	0			54.00
54.01 05401	RADIOLOGY - ULTRASOUND	2,253	0			54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	774	0			55.00
56.00 05600	RADIOISOTOPE	187	0			56.00
57.00 05700	CT SCAN	850	0			57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	236	0			58.00
59.00 05900	CARDIAC CATHETERIZATION	2,941	0			59.00
60.00 06000	LABORATORY	521	0			60.00
60.01 06001	BLOOD LABORATORY	0	0			60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	51	0			62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00 06400	INTRAVENOUS THERAPY	0	0			64.00
65.00 06500	RESPIRATORY THERAPY	2,597	0			65.00
66.00 06600	PHYSICAL THERAPY	61	0			66.00
67.00 06700	OCCUPATIONAL THERAPY	142	0			67.00
68.00 06800	SPEECH PATHOLOGY	89	0			68.00
69.00 06900	ELECTROCARDIOLOGY	663	0			69.00
69.01 06901	CARDIAC REHAB	37	0			69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	744	0			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	725	0			73.00
74.00 07400	RENAL DIALYSIS	0	0			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	735	0			90.00
91.00 09100	EMERGENCY	24,456	7,664			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	2,916	0			101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	215,363	7,664	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
191.00 19100	RESEARCH	0	0			191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
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Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2,869	0				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0				192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0				192.02
193.00 19300 NONPAID WORKERS	0	0				193.00
200.00 Cross Foot Adjustments			1,063	87,690	72,361	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	218,232	7,664	1,063	87,690	72,361	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	7,191,384	0	7,191,384	30.00
31.00	03100	565,205	0	565,205	31.00
31.01	03101	85,795	0	85,795	31.01
40.00	04000	95,005	0	95,005	40.00
41.00	04100	710,606	0	710,606	41.00
43.00	04300	496,638	0	496,638	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,401,790	0	1,401,790	50.00
50.01	05001	43,490	0	43,490	50.01
51.00	05100	317,331	0	317,331	51.00
52.00	05200	205,710	0	205,710	52.00
53.00	05300	0	0	0	53.00
54.00	05400	1,113,643	0	1,113,643	54.00
54.01	05401	130,675	0	130,675	54.01
55.00	05500	283,540	0	283,540	55.00
56.00	05600	206,369	0	206,369	56.00
57.00	05700	265,027	0	265,027	57.00
58.00	05800	109,562	0	109,562	58.00
59.00	05900	256,207	0	256,207	59.00
60.00	06000	684,916	0	684,916	60.00
60.01	06001	0	0	0	60.01
61.00	06100				61.00
62.00	06200	30,398	0	30,398	62.00
63.00	06300	0	0	0	63.00
64.00	06400	0	0	0	64.00
65.00	06500	213,056	0	213,056	65.00
66.00	06600	265,073	0	265,073	66.00
67.00	06700	222,958	0	222,958	67.00
68.00	06800	42,185	0	42,185	68.00
69.00	06900	24,450	0	24,450	69.00
69.01	06901	6,306	0	6,306	69.01
70.00	07000	26,970	0	26,970	70.00
71.00	07100	468,284	0	468,284	71.00
72.00	07200	519,478	0	519,478	72.00
73.00	07300	558,965	0	558,965	73.00
74.00	07400	118,348	0	118,348	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1,556,856	0	1,556,856	90.00
91.00	09100	767,233	0	767,233	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	21,324	0	21,324	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		19,004,777	0	19,004,777	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	37,179	0	37,179	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	781,227	0	781,227	192.00
192.01	19201	OTHER NON-REIMBURSABLE	92,881	0	92,881	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	177,517	0	177,517	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	161,114	0	161,114	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,254,695	0	20,254,695	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Prepared: 5/30/2018 8:22 am		
Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUIREMENTS)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,410,133				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,906	149,933,403			4.00
5.01 00550	DATA PROCESSING	9,190	4,039,363	100		5.01
5.02 00560	PURCHASING RECEIVING AND STORES	7,332	1,005,062	0	42,424,880	5.02
5.03 00570	ADMITTING	9,717	1,971,495	0	53,571	1,220,297,021
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	30,646	2,116,202	0	22,772	0
5.05 00590	OTHER A&G	99,579	11,099,348	100	63,357	0
5.06 00592	PATIENT TRANSPORTATION	0	578,272	0	3,982	0
7.00 00700	OPERATION OF PLANT	299,329	3,869,603	0	564,379	0
8.00 00800	LAUNDRY & LINEN SERVICE	17,825	0	0	221	0
9.00 00900	HOUSEKEEPING	20,635	4,544,467	0	455,505	0
10.00 01000	DIETARY	18,848	2,076,103	0	393,160	0
11.00 01100	CAFETERIA	13,177	1,174,508	0	397	0
13.00 01300	NURSING ADMINISTRATION	6,350	2,911,730	0	31,597	0
14.00 01400	CENTRAL SERVICES & SUPPLY	35,843	523,068	0	379,554	0
15.00 01500	PHARMACY	18,957	0	0	164,124	0
16.00 01600	MEDICAL RECORDS & LIBRARY	11,307	2,026,695	0	8,700	0
17.00 01700	SOCIAL SERVICE	1,629	465,581	0	0	0
17.01 01701	STAFF EDUCATION	11,147	0	0	0	0
17.02 01702	MEDICAL EDUCATION	374	17,205	0	601	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,467	0	0	0	0
23.00 02300	PARAMED ED PROGRAM	3,364	564,332	0	9,509	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	313,217	30,262,712	0	2,099,399	99,224,902
31.00 03100	INTENSIVE CARE UNIT	19,864	6,685,201	0	811,423	17,539,425
31.01 03101	NEONATAL ICU	2,258	2,041,118	0	5,731	5,674,848
40.00 04000	SUBPROVIDER - I PF	3,972	1,026,681	0	2,804	3,462,684
41.00 04100	SUBPROVIDER - I RF	31,243	2,973,707	0	115,449	7,909,819
43.00 04300	NURSERY	24,424	694,855	0	133,556	2,083,501
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	59,647	4,429,484	0	788,548	166,627,825
50.01 05001	ENDOSCOPY	0	1,231,684	0	750,608	19,475,289
51.00 05100	RECOVERY ROOM	14,546	1,168,467	0	42,803	10,706,556
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,003	2,824,170	0	121,495	5,364,077
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	53,059	2,416,511	0	157,768	36,949,293
54.01 05401	RADIOLOGY - ULTRASOUND	5,054	1,402,719	0	159,075	16,563,335
55.00 05500	RADIOLOGY-THERAPEUTIC	13,485	463,510	0	30,719	13,708,271
56.00 05600	RADIOISOTOPE	9,043	598,750	0	995,860	15,215,385
57.00 05700	CT SCAN	8,563	1,089,202	0	293,480	110,088,963
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,205	442,254	0	95,061	28,315,443
59.00 05900	CARDIAC CATHETERIZATION	8,393	2,042,870	0	818,912	72,518,351
60.00 06000	LABORATORY	23,518	3,529,926	0	3,051,642	143,572,843
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1,180,582	0	289,056	8,890,399
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	7,766	2,412,283	0	538,837	40,430,889
66.00 06600	PHYSICAL THERAPY	12,270	1,544,468	0	12,399	7,622,213
67.00 06700	OCCUPATIONAL THERAPY	10,545	1,228,704	0	13,986	6,200,644
68.00 06800	SPEECH PATHOLOGY	1,796	418,838	0	5,208	2,206,688
69.00 06900	ELECTROCARDIOLOGY	0	644,586	0	17,316	20,532,765
69.01 06901	CARDIAC REHAB	0	395,078	0	4,445	923,324
70.00 07000	ELECTROENCEPHALOGRAPHY	0	883,233	0	0	23,240,973
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,044,990	49,686,879
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,726,556	35,515,731
73.00 07300	DRUGS CHARGED TO PATIENTS	1,662	384,721	0	572,669	152,966,052
74.00 07400	RENAL DIALYSIS	4,383	0	0	27,628	8,471,203
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	76,181	2,883,925	0	101,536	22,277,687
91.00 09100	EMERGENCY	27,063	7,088,086	0	1,793,459	62,988,278
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	2,012,787	0	85,950	3,342,486
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,369,167	125,384,146	100	41,859,797	1,220,297,021

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	39,731	0	167,316	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	26,711	21,772,009	0	389,088	0
192.01 19201	OTHER NON-REIMBURSABLE	3,457	2,575,181	0	8,679	0
192.02 19202	FAMILY HEALTH/GARY COMM HEALTH	8,997	162,336	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
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)	20,254,695	35,966,699	11,734,804	3,697,648	3,036,023
203.00	Unit cost multiplier (Wkst. B, Part I)	14.363677	0.239884	117,348.04000	0.087158	0.002488
204.00	Cost to be allocated (per Wkst. B, Part II)		84,832	134,288	105,883	140,822
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000566	1,342.880000	0.002496	0.000115
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: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
	5.04	5A.05	5.05	5.06	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,220,297,021				5.04
5.05 00590	OTHER A&G	0	-34,808,999	310,871,668		5.05
5.06 00592	PATIENT TRANSPORTATION	0	0	767,040	48,667	5.06
7.00 00700	OPERATION OF PLANT	0	0	24,139,683	0	948,434 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	1,609,477	0	17,825 8.00
9.00 00900	HOUSEKEEPING	0	0	7,227,080	0	20,635 9.00
10.00 01000	DIETARY	0	0	4,550,839	0	18,848 10.00
11.00 01100	CAFETERIA	0	0	1,664,835	0	13,177 11.00
13.00 01300	NURSING ADMINISTRATION	0	0	4,301,613	0	6,350 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	2,629,310	0	35,843 14.00
15.00 01500	PHARMACY	0	0	5,456,613	0	18,957 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	3,375,096	0	11,307 16.00
17.00 01700	SOCIAL SERVICE	0	0	600,664	0	1,629 17.00
17.01 01701	STAFF EDUCATION	0	0	160,112	0	11,147 17.01
17.02 01702	MEDICAL EDUCATION	0	0	64,541	0	374 17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	210,423	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	110,915	0	4,467 22.00
23.00 02300	PARAMED ED PROGRAM	0	0	494,174	0	3,364 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	99,224,902	0	48,149,026	19,959	313,217 30.00
31.00 03100	INTENSIVE CARE UNIT	17,539,425	0	10,141,821	277	19,864 31.00
31.01 03101	NEONATAL ICU	5,674,848	0	2,775,773	0	2,258 31.01
40.00 04000	SUBPROVIDER - IPF	3,462,684	0	1,440,316	21	3,972 40.00
41.00 04100	SUBPROVIDER - IRF	7,909,819	0	4,647,948	553	31,243 41.00
43.00 04300	NURSERY	2,083,501	0	1,441,752	0	24,424 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	166,627,825	0	9,991,691	4	59,647 50.00
50.01 05001	ENDOSCOPY	19,475,289	0	3,368,197	1,207	0 50.01
51.00 05100	RECOVERY ROOM	10,706,556	0	1,873,199	1	14,546 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,364,077	0	3,993,265	377	7,003 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	36,949,293	0	5,750,685	4,866	53,059 54.00
54.01 05401	RADIOLOGY - ULTRASOUND	16,563,335	0	2,323,078	5,068	5,054 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	13,708,271	0	1,653,847	334	13,485 55.00
56.00 05600	RADIOISOTOPE	15,215,385	0	2,152,616	2,614	9,043 56.00
57.00 05700	CT SCAN	110,088,963	0	2,901,925	7,729	8,563 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	28,315,443	0	1,017,275	2,869	4,205 58.00
59.00 05900	CARDIAC CATHETERIZATION	72,518,351	0	4,044,716	1,773	8,393 59.00
60.00 06000	LABORATORY	143,572,843	0	12,594,987	1	23,518 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,890,399	0	1,850,499	0	385 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	40,430,889	0	4,187,018	42	7,766 65.00
66.00 06600	PHYSICAL THERAPY	7,622,213	0	2,273,210	0	12,270 66.00
67.00 06700	OCCUPATIONAL THERAPY	6,200,644	0	1,825,369	0	10,545 67.00
68.00 06800	SPEECH PATHOLOGY	2,206,688	0	637,418	0	1,796 68.00
69.00 06900	ELECTROCARDIOLOGY	20,532,765	0	1,058,272	205	0 69.00
69.01 06901	CARDIAC REHAB	923,324	0	608,907	0	0 69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	23,240,973	0	1,497,762	402	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,686,879	0	13,436,603	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	35,515,731	0	15,167,230	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	152,966,052	0	14,984,417	0	1,662 73.00
74.00 07400	RENAL DIALYSIS	8,471,203	0	2,230,123	0	4,383 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	22,277,687	0	6,897,724	39	76,181 90.00
91.00 09100	EMERGENCY	62,988,278	0	12,353,145	325	27,063 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,342,486	0	2,867,611	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,220,297,021	-34,808,999	259,499,840	48,666	907,468 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	264,450	0	1,801 190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	45,980,657	0	26,711	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	4,743,255	1	3,457	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	383,466	0	8,997	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,358,075		34,808,999	852,927	26,842,652	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004391		0.111972	17.525777	28.302077	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	441,444		1,571,049	4,214	4,425,066	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000362		0.005054	0.086588	4.665655	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: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet B-1	
Date/Time Prepared: 5/30/2018 8:22 am								
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)			
	8.00	9.00	10.00	11.00	13.00			
GENERAL SERVICE COST CENTERS								
1.00 00100	CAP REL COSTS-BLDG & FIXT							1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01 00550	DATA PROCESSING							5.01
5.02 00560	PURCHASING RECEIVING AND STORES							5.02
5.03 00570	ADMITTING							5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05 00590	OTHER A&G							5.05
5.06 00592	PATIENT TRANSPORTATION							5.06
7.00 00700	OPERATION OF PLANT							7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,251,221						8.00
9.00 00900	HOUSEKEEPING	0	909,974					9.00
10.00 01000	DIETARY	0	18,848	352,191				10.00
11.00 01100	CAFETERIA	0	13,177	0	2,667,928			11.00
13.00 01300	NURSING ADMINISTRATION	0	6,350	0	63,165	1,808,806		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	24,538	35,843	0	27,026	0		14.00
15.00 01500	PHARMACY	14	18,957	0	0	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,307	0	83,117	0		16.00
17.00 01700	SOCIAL SERVICE	0	1,629	0	14,979	14,979		17.00
17.01 01701	STAFF EDUCATION	0	11,147	0	0	0		17.01
17.02 01702	MEDICAL EDUCATION	0	374	0	306	0		17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,467	0	0	0		22.00
23.00 02300	PARAMED PROGRAM	0	3,364	0	20,399	20,399		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	1,053,107	313,217	245,759	946,399	946,399		30.00
31.00 03100	INTENSIVE CARE UNIT	55,750	19,864	43,463	168,096	168,096		31.00
31.01 03101	NEONATAL ICU	49,211	2,258	0	45,825	45,825		31.01
40.00 04000	SUBPROVIDER - IPF	0	3,972	0	27,268	27,268		40.00
41.00 04100	SUBPROVIDER - IRF	0	31,243	31,390	89,811	89,811		41.00
43.00 04300	NURSERY	45,746	24,424	0	17,652	17,652		43.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	221,757	59,647	0	129,836	129,836		50.00
50.01 05001	ENDOSCOPY	24,862	0	2	33,046	33,046		50.01
51.00 05100	RECOVERY ROOM	58,048	14,546	0	27,057	27,057		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	49,593	7,003	12,491	75,465	75,465		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	73,737	53,059	0	78,882	0		54.00
54.01 05401	RADIOLOGY - ULTRASOUND	12,511	5,054	0	33,042	0		54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	3,343	13,485	0	11,940	0		55.00
56.00 05600	RADIOISOTOPE	27,053	9,043	0	13,641	0		56.00
57.00 05700	CT SCAN	16,995	8,563	0	31,066	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	6,794	4,205	0	11,608	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	48,542	8,393	3,831	47,739	0		59.00
60.00 06000	LABORATORY	0	23,518	0	110,043	0		60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0		60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	385	0	60,768	0		61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0		62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0		63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	3,266	7,766	0	71,701	0		65.00
66.00 06600	PHYSICAL THERAPY	26,785	12,270	0	39,924	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	0	10,545	0	29,772	0		67.00
68.00 06800	SPEECH PATHOLOGY	0	1,796	1,042	9,342	0		68.00
69.00 06900	ELECTROCARDIOLOGY	12,732	0	0	21,113	0		69.00
69.01 06901	CARDIAC REHAB	7,525	0	0	11,725	0		69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	17	23,269	0		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,981	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,662	0	0	0		73.00
74.00 07400	RENAL DIALYSIS	102,179	4,383	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
90.00 09000	CLINIC	72,335	76,181	0	71,882	0		90.00
91.00 09100	EMERGENCY	236,953	27,063	14,196	209,301	212,973		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS								
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,233,376	869,008	352,191	2,665,186	1,808,806		118.00
NONREIMBURSABLE COST CENTERS								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,801	0	2,742	0		190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	17,845	26,711	0	0	0	192.00
192.01	19201 OTHER NON-REIMBURSABLE	0	3,457	0	0	0	192.01
192.02	19202 FAMILY HEALTH/GARY COMM HEALTH	0	8,997	0	0	0	192.02
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,294,178	8,620,324	5,772,394	2,349,014	5,078,761	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.019082	9.473154	16.389953	0.880464	2.807798	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	347,333	432,905	392,788	266,098	153,624	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.154286	0.475733	1.115270	0.099740	0.084931	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: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Prepared: 5/30/2018 8:22 am		
Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
	14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER A&G					5.05
5.06 00592	PATIENT TRANSPORTATION					5.06
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	25,771,546				14.00
15.00 01500	PHARMACY	0	15,032,603			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	1,220,297,021		16.00
17.00 01700	SOCIAL SERVICE	0	0	0	801	17.00
17.01 01701	STAFF EDUCATION	0	0	0	0	17.01
17.02 01702	MEDICAL EDUCATION	0	0	0	0	17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED PROGRAM	0	0	0	82	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	204	99,224,902	618	63,353
31.00 03100	INTENSIVE CARE UNIT	0	0	17,539,425	0	12,239
31.01 03101	NEONATAL ICU	0	0	5,674,848	0	3,941
40.00 04000	SUBPROVIDER - I/PF	0	0	3,462,684	0	1,349
41.00 04100	SUBPROVIDER - IRF	0	0	7,909,819	137	7,272
43.00 04300	NURSERY	0	0	2,083,501	0	297
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	166,627,825	0	6,717
50.01 05001	ENDOSCOPY	0	0	19,475,289	0	371
51.00 05100	RECOVERY ROOM	0	0	10,706,556	0	1,276
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	5,364,077	0	4,647
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	36,949,293	0	1,864
54.01 05401	RADIOLOGY - ULTRASOUND	0	0	16,563,335	0	1,336
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	13,708,271	0	459
56.00 05600	RADIOISOTOPE	0	0	15,215,385	0	111
57.00 05700	CT SCAN	0	0	110,088,963	0	504
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	28,315,443	0	140
59.00 05900	CARDIAC CATHETERIZATION	0	0	72,518,351	0	1,744
60.00 06000	LABORATORY	0	1,660,813	143,572,843	0	309
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	8,890,399	0	30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	40,430,889	0	1,540
66.00 06600	PHYSICAL THERAPY	0	0	7,622,213	0	36
67.00 06700	OCCUPATIONAL THERAPY	0	0	6,200,644	0	84
68.00 06800	SPEECH PATHOLOGY	0	0	2,206,688	0	53
69.00 06900	ELECTROCARDIOLOGY	0	0	20,532,765	0	393
69.01 06901	CARDIAC REHAB	0	0	923,324	0	22
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	23,240,973	0	441
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,044,990	0	49,686,879	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	13,726,556	0	35,515,731	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	13,023,191	152,966,052	0	430
74.00 07400	RENAL DIALYSIS	0	0	8,471,203	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	22,277,687	0	436
91.00 09100	EMERGENCY	0	0	62,988,278	46	14,502
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	11,044	3,342,486	0	1,729
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	25,771,546	14,695,252	1,220,297,021	801	127,707
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
		14.00	15.00	16.00	17.00	17.01	
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	337,351	0	1,701	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,326,497	6,783,720	4,253,319	784,704	599,120
203.00		Unit cost multiplier (Wkst. B, Part I)	0.167879	0.451267	0.003485	979.655431	4.629698
204.00		Cost to be allocated (per Wkst. B, Part II)	720,134	397,747	247,061	37,839	218,232
205.00		Unit cost multiplier (Wkst. B, Part II)	0.027943	0.026459	0.000202	47.239700	1.686387
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: 15-0002

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS				PARAMED PROGRAM (ASSIGNED TIME)		
	MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
	17.02	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550	DATA PROCESSING						5.01
5.02 00560	PURCHASING RECEIVING AND STORES						5.02
5.03 00570	ADMINISTRATIVE						5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590	OTHER A&G						5.05
5.06 00592	PATIENT TRANSPORTATION						5.06
7.00 00700	OPERATION OF PLANT						7.00
8.00 00800	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPING						9.00
10.00 01000	DIETARY						10.00
11.00 01100	CAFETERIA						11.00
13.00 01300	NURSING ADMINISTRATION						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY						14.00
15.00 01500	PHARMACY						15.00
16.00 01600	MEDICAL RECORDS & LIBRARY						16.00
17.00 01700	SOCIAL SERVICE						17.00
17.01 01701	STAFF EDUCATION						17.01
17.02 01702	MEDICAL EDUCATION	100					17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	100				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100			22.00
23.00 02300	PARAMED PROGRAM	0			100		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0		30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
31.01 03101	NEONATAL ICU	0	0	0	0		31.01
40.00 04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00 04300	NURSERY	0	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	0		50.00
50.01 05001	ENDOSCOPY	0	0	0	0		50.01
51.00 05100	RECOVERY ROOM	0	0	0	0		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
54.01 05401	RADIOLOGY - ULTRASOUND	0	0	0	0		54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00 05600	RADIOISOTOPE	0	0	0	0		56.00
57.00 05700	CT SCAN	0	0	0	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 06000	LABORATORY	0	0	0	0		60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0		60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0		61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01 06901	CARDIAC REHAB	0	0	0	0		69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0		90.00
91.00 09100	EMERGENCY	100	100	100	100		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100	100		118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
		17.02	21.00				22.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	86,165	233,984	292,076	752,201	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	861.650000	2,339.840000	2,920.760000	7,522.010000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,664	1,063	87,690	72,361	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	76.640000	10.630000	876.900000	723.610000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2018 8:22 am

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
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	75,558,456		75,558,456	0	75,558,456 30.00	
31.00	03100 INTENSIVE CARE UNIT	13,539,584		13,539,584	0	13,539,584 31.00	
31.01	03101 NEONATAL ICU	3,429,065		3,429,065	0	3,429,065 31.01	
40.00	04000 SUBPROVIDER - I PF	1,870,885		1,870,885	0	1,870,885 40.00	
41.00	04100 SUBPROVIDER - I RF	7,399,465		7,399,465	0	7,399,465 41.00	
43.00	04300 NURSERY	2,646,170		2,646,170	0	2,646,170 43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,680,969		14,680,969	0	14,680,969 50.00	
50.01	05001 ENDOSCOPY	3,983,335		3,983,335	0	3,983,335 50.01	
51.00	05100 RECOVERY ROOM	2,834,610		2,834,610	0	2,834,610 51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,285,353		5,285,353	0	5,285,353 52.00	
53.00	05300 ANESTHESIOLOGY	0		0	0	0 53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,766,192		8,766,192	0	8,766,192 54.00	
54.01	05401 RADIOLOGY - ULTRASOUND	2,968,685		2,968,685	0	2,968,685 54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	2,418,103		2,418,103	9,254	2,427,357 55.00	
56.00	05600 RADIOISOTOPE	2,874,182		2,874,182	0	2,874,182 56.00	
57.00	05700 CT SCAN	4,116,450		4,116,450	0	4,116,450 57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,456,778		1,456,778	0	1,456,778 58.00	
59.00	05900 CARDIAC CATHETERIZATION	5,260,821		5,260,821	0	5,260,821 59.00	
60.00	06000 LABORATORY	16,241,830		16,241,830	0	16,241,830 60.00	
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0 61.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,156,872		2,156,872	0	2,156,872 62.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0 63.00	
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0 64.00	
65.00	06500 RESPIRATORY THERAPY	5,164,436	0	5,164,436	0	5,164,436 65.00	
66.00	06600 PHYSICAL THERAPY	3,080,426	0	3,080,426	0	3,080,426 66.00	
67.00	06700 OCCUPATIONAL THERAPY	2,476,309	0	2,476,309	0	2,476,309 67.00	
68.00	06800 SPEECH PATHOLOGY	809,874	0	809,874	0	809,874 68.00	
69.00	06900 ELECTROCARDIOLOGY	1,285,302		1,285,302	0	1,285,302 69.00	
69.01	06901 CARDIAC REHAB	698,400		698,400	0	698,400 69.01	
70.00	07000 ELECTROENCEPHALOGRAPHY	1,776,318		1,776,318	0	1,776,318 70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,136,386		17,136,386	0	17,136,386 71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,301,610		19,301,610	0	19,301,610 72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	23,137,051		23,137,051	0	23,137,051 73.00	
74.00	07400 RENAL DIALYSIS	2,779,054		2,779,054	0	2,779,054 74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	10,765,177		10,765,177	30,331	10,795,508 90.00	
91.00	09100 EMERGENCY	17,190,856		17,190,856	15,044	17,205,900 91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15,391,529		15,391,529		15,391,529 92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	3,213,341		3,213,341		3,213,341 101.00	
200.00	Subtotal (see instructions)	301,693,874	0	301,693,874	54,629	301,748,503 200.00	
201.00	Less Observation Beds	15,391,529		15,391,529		15,391,529 201.00	
202.00	Total (see instructions)	286,302,345	0	286,302,345	54,629	286,356,974 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/30/2018 8:22 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	69,277,711		69,277,711				30.00
31.00	03100	INTENSIVE CARE UNIT	17,539,425		17,539,425				31.00
31.01	03101	NEONATAL ICU	5,674,848		5,674,848				31.01
40.00	04000	SUBPROVIDER - IPF	3,462,684		3,462,684				40.00
41.00	04100	SUBPROVIDER - IRF	7,909,819		7,909,819				41.00
43.00	04300	NURSERY	2,083,501		2,083,501				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	98,778,524	67,849,301	166,627,825	0.088106	0.000000		50.00
50.01	05001	ENDOSCOPY	4,045,767	15,429,522	19,475,289	0.204533	0.000000		50.01
51.00	05100	RECOVERY ROOM	5,058,324	5,648,232	10,706,556	0.264755	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,063,071	2,301,006	5,364,077	0.985324	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,742,397	27,206,896	36,949,293	0.237249	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	4,856,159	11,707,176	16,563,335	0.179232	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,279,338	12,428,933	13,708,271	0.176397	0.000000		55.00
56.00	05600	RADIO SOTOPE	5,433,492	9,781,893	15,215,385	0.188900	0.000000		56.00
57.00	05700	CT SCAN	40,625,643	69,463,320	110,088,963	0.037392	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,276,983	18,038,460	28,315,443	0.051448	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	34,860,415	37,657,936	72,518,351	0.072545	0.000000		59.00
60.00	06000	LABORATORY	59,310,157	84,262,686	143,572,843	0.113126	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,047,945	1,842,454	8,890,399	0.242607	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	35,292,134	5,138,755	40,430,889	0.127735	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	7,240,714	381,499	7,622,213	0.404138	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,939,855	260,789	6,200,644	0.399363	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,987,691	218,997	2,206,688	0.367009	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	11,222,375	9,310,390	20,532,765	0.062598	0.000000		69.00
69.01	06901	CARDIAC REHAB	191,541	731,783	923,324	0.756398	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,556,277	13,684,696	23,240,973	0.076430	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,048,252	23,638,627	49,686,879	0.344888	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,576,222	12,939,509	35,515,731	0.543466	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,789,051	44,177,001	152,966,052	0.151256	0.000000		73.00
74.00	07400	RENAL DIALYSIS	7,866,810	604,393	8,471,203	0.328059	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	580,665	21,697,022	22,277,687	0.483227	0.000000		90.00
91.00	09100	EMERGENCY	15,807,961	47,180,317	62,988,278	0.272922	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,942,034	23,005,157	29,947,191	0.513956	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,342,486	3,342,486				101.00
200.00		Subtotal (see instructions)	650,367,785	569,929,236	1,220,297,021				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	650,367,785	569,929,236	1,220,297,021				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 8:22 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL ICU		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088106	50.00
50.01	05001	ENDOSCOPY	0.204533	50.01
51.00	05100	RECOVERY ROOM	0.264755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.985324	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237249	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.179232	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177072	55.00
56.00	05600	RADIOISOTOPE	0.188900	56.00
57.00	05700	CT SCAN	0.037392	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051448	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.072545	59.00
60.00	06000	LABORATORY	0.113126	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.127735	65.00
66.00	06600	PHYSICAL THERAPY	0.404138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.399363	67.00
68.00	06800	SPEECH PATHOLOGY	0.367009	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062598	69.00
69.01	06901	CARDIAC REHAB	0.756398	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076430	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.543466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151256	73.00
74.00	07400	RENAL DIALYSIS	0.328059	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.484588	90.00
91.00	09100	EMERGENCY	0.273160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	75,558,456		75,558,456	0	75,558,456
31.00	03100 INTENSIVE CARE UNIT	13,539,584		13,539,584	0	13,539,584
31.01	03101 NEONATAL ICU	3,429,065		3,429,065	0	3,429,065
40.00	04000 SUBPROVIDER - I/PF	1,870,885		1,870,885	0	1,870,885
41.00	04100 SUBPROVIDER - I/RF	7,399,465		7,399,465	0	7,399,465
43.00	04300 NURSERY	2,646,170		2,646,170	0	2,646,170
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	14,680,969		14,680,969	0	14,680,969
50.01	05001 ENDOSCOPY	3,983,335		3,983,335	0	3,983,335
51.00	05100 RECOVERY ROOM	2,834,610		2,834,610	0	2,834,610
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,285,353		5,285,353	0	5,285,353
53.00	05300 ANESTHESIOLOGY	0		0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,766,192		8,766,192	0	8,766,192
54.01	05401 RADIOLOGY - ULTRASOUND	2,968,685		2,968,685	0	2,968,685
55.00	05500 RADIOLOGY-THERAPEUTIC	2,418,103		2,418,103	9,254	2,427,357
56.00	05600 RADIOISOTOPE	2,874,182		2,874,182	0	2,874,182
57.00	05700 CT SCAN	4,116,450		4,116,450	0	4,116,450
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,456,778		1,456,778	0	1,456,778
59.00	05900 CARDIAC CATHETERIZATION	5,260,821		5,260,821	0	5,260,821
60.00	06000 LABORATORY	16,241,830		16,241,830	0	16,241,830
60.01	06001 BLOOD LABORATORY	0		0	0	0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,156,872		2,156,872	0	2,156,872
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0
65.00	06500 RESPIRATORY THERAPY	5,164,436	0	5,164,436	0	5,164,436
66.00	06600 PHYSICAL THERAPY	3,080,426	0	3,080,426	0	3,080,426
67.00	06700 OCCUPATIONAL THERAPY	2,476,309	0	2,476,309	0	2,476,309
68.00	06800 SPEECH PATHOLOGY	809,874	0	809,874	0	809,874
69.00	06900 ELECTROCARDIOLOGY	1,285,302		1,285,302	0	1,285,302
69.01	06901 CARDIAC REHAB	698,400		698,400	0	698,400
70.00	07000 ELECTROENCEPHALOGRAPHY	1,776,318		1,776,318	0	1,776,318
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,136,386		17,136,386	0	17,136,386
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,301,610		19,301,610	0	19,301,610
73.00	07300 DRUGS CHARGED TO PATIENTS	23,137,051		23,137,051	0	23,137,051
74.00	07400 RENAL DIALYSIS	2,779,054		2,779,054	0	2,779,054
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	10,765,177		10,765,177	30,331	10,795,508
91.00	09100 EMERGENCY	17,190,856		17,190,856	15,044	17,205,900
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15,391,529		15,391,529		15,391,529
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	3,213,341		3,213,341		3,213,341
200.00	Subtotal (see instructions)	301,693,874	0	301,693,874	54,629	301,748,503
201.00	Less Observation Beds	15,391,529		15,391,529		15,391,529
202.00	Total (see instructions)	286,302,345	0	286,302,345	54,629	286,356,974

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/30/2018 8:22 am		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	69,277,711		69,277,711				30.00
31.00	03100	INTENSIVE CARE UNIT	17,539,425		17,539,425				31.00
31.01	03101	NEONATAL ICU	5,674,848		5,674,848				31.01
40.00	04000	SUBPROVIDER - IPF	3,462,684		3,462,684				40.00
41.00	04100	SUBPROVIDER - IRF	7,909,819		7,909,819				41.00
43.00	04300	NURSERY	2,083,501		2,083,501				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	98,778,524	67,849,301	166,627,825	0.088106	0.000000		50.00
50.01	05001	ENDOSCOPY	4,045,767	15,429,522	19,475,289	0.204533	0.000000		50.01
51.00	05100	RECOVERY ROOM	5,058,324	5,648,232	10,706,556	0.264755	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,063,071	2,301,006	5,364,077	0.985324	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,742,397	27,206,896	36,949,293	0.237249	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	4,856,159	11,707,176	16,563,335	0.179232	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,279,338	12,428,933	13,708,271	0.176397	0.000000		55.00
56.00	05600	RADIO SOTOPE	5,433,492	9,781,893	15,215,385	0.188900	0.000000		56.00
57.00	05700	CT SCAN	40,625,643	69,463,320	110,088,963	0.037392	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,276,983	18,038,460	28,315,443	0.051448	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	34,860,415	37,657,936	72,518,351	0.072545	0.000000		59.00
60.00	06000	LABORATORY	59,310,157	84,262,686	143,572,843	0.113126	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,047,945	1,842,454	8,890,399	0.242607	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	35,292,134	5,138,755	40,430,889	0.127735	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	7,240,714	381,499	7,622,213	0.404138	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,939,855	260,789	6,200,644	0.399363	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,987,691	218,997	2,206,688	0.367009	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	11,222,375	9,310,390	20,532,765	0.062598	0.000000		69.00
69.01	06901	CARDIAC REHAB	191,541	731,783	923,324	0.756398	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,556,277	13,684,696	23,240,973	0.076430	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,048,252	23,638,627	49,686,879	0.344888	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,576,222	12,939,509	35,515,731	0.543466	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,789,051	44,177,001	152,966,052	0.151256	0.000000		73.00
74.00	07400	RENAL DIALYSIS	7,866,810	604,393	8,471,203	0.328059	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	580,665	21,697,022	22,277,687	0.483227	0.000000		90.00
91.00	09100	EMERGENCY	15,807,961	47,180,317	62,988,278	0.272922	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,942,034	23,005,157	29,947,191	0.513956	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,342,486	3,342,486				101.00
200.00		Subtotal (see instructions)	650,367,785	569,929,236	1,220,297,021				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	650,367,785	569,929,236	1,220,297,021				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 8:22 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	03101 NEONATAL ICU			31.01
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIO SOTOP	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Prepared: 5/30/2018 8:22 am
Title XVIII			Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,191,384	0	7,191,384	90,715	79.27	30.00
31.00	INTENSIVE CARE UNIT	565,205		565,205	8,536	66.21	31.00
31.01	NEONATAL ICU	85,795		85,795	2,820	30.42	31.01
40.00	SUBPROVIDER - IPF	95,005	0	95,005	2,343	40.55	40.00
41.00	SUBPROVIDER - IRF	710,606	0	710,606	9,525	74.60	41.00
43.00	NURSERY	496,638		496,638	2,849	174.32	43.00
200.00	Total (lines 30 through 199)	9,144,633		9,144,633	116,788		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	27,937	2,214,566	30.00
31.00	INTENSIVE CARE UNIT	3,570	236,370	31.00
31.01	NEONATAL ICU	0	0	31.01
40.00	SUBPROVIDER - IPF	925	37,509	40.00
41.00	SUBPROVIDER - IRF	5,800	432,680	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	38,232	2,921,125	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII							
Hospital							
PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,401,790	166,627,825	0.008413	34,173,838	287,504	50.00
50.01	05001 ENDOSCOPY	43,490	19,475,289	0.002233	1,781,266	3,978	50.01
51.00	05100 RECOVERY ROOM	317,331	10,706,556	0.029639	1,591,470	47,170	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	205,710	5,364,077	0.038350	120,037	4,603	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,113,643	36,949,293	0.030140	4,413,398	133,020	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	130,675	16,563,335	0.007889	2,308,505	18,212	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	283,540	13,708,271	0.020684	519,463	10,745	55.00
56.00	05600 RADIOISOTOPE	206,369	15,215,385	0.013563	2,290,286	31,063	56.00
57.00	05700 CT SCAN	265,027	110,088,963	0.002407	15,483,864	37,270	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	109,562	28,315,443	0.003869	4,182,906	16,184	58.00
59.00	05900 CARDIAC CATHETERIZATION	256,207	72,518,351	0.003533	14,826,580	52,382	59.00
60.00	06000 LABORATORY	684,916	143,572,843	0.004771	22,886,860	109,193	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30,398	8,890,399	0.003419	3,065,508	10,481	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	213,056	40,430,889	0.005270	13,168,276	69,397	65.00
66.00	06600 PHYSICAL THERAPY	265,073	7,622,213	0.034776	1,627,744	56,606	66.00
67.00	06700 OCCUPATIONAL THERAPY	222,958	6,200,644	0.035957	1,123,450	40,396	67.00
68.00	06800 SPEECH PATHOLOGY	42,185	2,206,688	0.019117	735,368	14,058	68.00
69.00	06900 ELECTROCARDIOLOGY	24,450	20,532,765	0.001191	5,113,000	6,090	69.00
69.01	06901 CARDIAC REHAB	6,306	923,324	0.006830	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	26,970	23,240,973	0.001160	3,024,434	3,508	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	468,284	49,686,879	0.009425	8,337,826	78,584	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	519,478	35,515,731	0.014627	8,528,874	124,752	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	558,965	152,966,052	0.003654	41,222,169	150,626	73.00
74.00	07400 RENAL DIALYSIS	118,348	8,471,203	0.013971	3,611,201	50,452	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,556,856	22,277,687	0.069884	207,360	14,491	90.00
91.00	09100 EMERGENCY	767,233	62,988,278	0.012181	8,995,177	109,570	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,464,904	29,947,191	0.048916	2,906,907	142,194	92.00
200.00	Total (lines 50 through 199)	11,303,724	1,111,006,547		206,245,767	1,622,529	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
31.01	03101	NEONATAL ICU	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	90,715	0.00	27,937	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	8,536	0.00	3,570	31.00	
31.01	03101	NEONATAL ICU	0	0	2,820	0.00	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	2,343	0.00	925	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	9,525	0.00	5,800	41.00	
43.00	04300	NURSERY	0	0	2,849	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	116,788	0.00	38,232	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
31.01	03101	NEONATAL ICU	0						31.01
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description	Title XVIII			Hospital		PPS	
	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	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	752,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	752,201	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		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	166,627,825	0.000000	50.00
50.01	05001	ENDOSCOPY	0	0	0	19,475,289	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	10,706,556	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,364,077	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,949,293	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	16,563,335	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,708,271	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,215,385	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	110,088,963	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	28,315,443	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	72,518,351	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	143,572,843	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,890,399	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	40,430,889	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,622,213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,200,644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,206,688	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,532,765	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	923,324	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	23,240,973	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,686,879	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,515,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	152,966,052	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,471,203	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	22,277,687	0.000000	90.00
91.00	09100	EMERGENCY	0	752,201	752,201	62,988,278	0.011942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	29,947,191	0.000000	92.00
200.00		Total (lines 50 through 199)	0	752,201	752,201	1,111,006,547		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description		Title XVIII				Hospital	
		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)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	34,173,838	0	17,458,962	0	50.00
50.01	05001 ENDOSCOPY	0.000000	1,781,266	0	4,496,631	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	1,591,470	0	1,869,268	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	120,037	0	354,772	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,413,398	0	5,387,445	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	2,308,505	0	2,042,320	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	519,463	0	3,926,304	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	2,290,286	0	3,078,956	0	56.00
57.00	05700 CT SCAN	0.000000	15,483,864	0	16,369,174	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,182,906	0	4,401,904	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	14,826,580	0	13,496,360	0	59.00
60.00	06000 LABORATORY	0.000000	22,886,860	0	7,244,093	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,065,508	0	228,670	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	13,168,276	0	572,600	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,627,744	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,123,450	0	20,036	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	735,368	0	26,299	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	5,113,000	0	2,406,031	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	230,991	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	3,024,434	0	2,909,673	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,337,826	0	5,308,103	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	8,528,874	0	4,218,870	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	41,222,169	0	10,794,351	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	3,611,201	0	226,250	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	207,360	0	3,995,129	0	90.00
91.00	09100 EMERGENCY	0.011942	8,995,177	107,420	8,062,780	96,286	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,906,907	0	2,814,605	0	92.00
200.00	Total (lines 50 through 199)		206,245,767	107,420	121,940,577	96,286	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 8:22 am				
		Title XVIII	Hospital	PPS				
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.088106	17,458,962	0	60	1,538,239	50.00
50.01	05001	ENDOSCOPY	0.204533	4,496,631	0	0	919,709	50.01
51.00	05100	RECOVERY ROOM	0.264755	1,869,268	0	0	494,898	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.985324	354,772	0	0	349,565	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237249	5,387,445	1	471	1,278,166	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.179232	2,042,320	0	0	366,049	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176397	3,926,304	0	6	692,588	55.00
56.00	05600	RADIO SOTOP	0.188900	3,078,956	0	117	581,615	56.00
57.00	05700	CT SCAN	0.037392	16,369,174	20	6,473	612,076	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051448	4,401,904	3	939	226,469	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.072545	13,496,360	3	1,109	979,093	59.00
60.00	06000	LABORATORY	0.113126	7,244,093	0	0	819,495	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	228,670	0	71	55,477	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.127735	572,600	0	0	73,141	65.00
66.00	06600	PHYSICAL THERAPY	0.404138	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.399363	20,036	0	0	8,002	67.00
68.00	06800	SPEECH PATHOLOGY	0.367009	26,299	0	0	9,652	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062598	2,406,031	0	0	150,613	69.00
69.01	06901	CARDIAC REHAB	0.756398	230,991	0	0	174,721	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076430	2,909,673	0	0	222,386	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	5,308,103	0	0	1,830,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.543466	4,218,870	10,020	0	2,292,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151256	10,794,351	187	62,045	1,632,710	73.00
74.00	07400	RENAL DIALYSIS	0.328059	226,250	0	0	74,223	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.483227	3,995,129	1	391	1,930,554	90.00
91.00	09100	EMERGENCY	0.272922	8,062,780	0	111	2,200,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	2,814,605	0	0	1,446,583	92.00
200.00		Subtotal (see instructions)		121,940,577	10,235	71,793	20,960,047	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		121,940,577	10,235	71,793	20,960,047	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	5		50.00
50.01 05001 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	112		54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	1		55.00
56.00 05600 RADIOISOTOPE	0	22		56.00
57.00 05700 CT SCAN	1	242		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	48		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	80		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	17		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5,446	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	28	9,385		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	189		90.00
91.00 09100 EMERGENCY	0	30		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	5,475	10,131		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	5,475	10,131		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 5/30/2018 8:22 am	
Title XVIII				Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,401,790	166,627,825	0.008413	0	50.00
50.01	05001	ENDOSCOPY	43,490	19,475,289	0.002233	0	50.01
51.00	05100	RECOVERY ROOM	317,331	10,706,556	0.029639	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,710	5,364,077	0.038350	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,643	36,949,293	0.030140	7,114	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	130,675	16,563,335	0.007889	6,998	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	283,540	13,708,271	0.020684	0	55.00
56.00	05600	RADIOISOTOPE	206,369	15,215,385	0.013563	12,998	56.00
57.00	05700	CT SCAN	265,027	110,088,963	0.002407	26,524	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	109,562	28,315,443	0.003869	3,212	58.00
59.00	05900	CARDIAC CATHETERIZATION	256,207	72,518,351	0.003533	0	59.00
60.00	06000	LABORATORY	684,916	143,572,843	0.004771	140,395	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,398	8,890,399	0.003419	13,093	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	213,056	40,430,889	0.005270	445	65.00
66.00	06600	PHYSICAL THERAPY	265,073	7,622,213	0.034776	6,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,958	6,200,644	0.035957	3,316	67.00
68.00	06800	SPEECH PATHOLOGY	42,185	2,206,688	0.019117	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,450	20,532,765	0.001191	20,435	69.00
69.01	06901	CARDIAC REHAB	6,306	923,324	0.006830	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	26,970	23,240,973	0.001160	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	468,284	49,686,879	0.009425	92	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	519,478	35,515,731	0.014627	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,965	152,966,052	0.003654	323,642	73.00
74.00	07400	RENAL DIALYSIS	118,348	8,471,203	0.013971	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,556,856	22,277,687	0.069884	0	90.00
91.00	09100	EMERGENCY	767,233	62,988,278	0.012181	60,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	29,947,191	0.000000	1,335	92.00
200.00		Total (lines 50 through 199)	9,838,820	1,111,006,547		626,612	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	752,201	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	752,201	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col 8)	Ratio of Cost to Charges (col 5 ÷ col 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	166,627,825	0.000000	50.00
50.01	05001	ENDOSCOPY	0	0	0	19,475,289	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	10,706,556	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,364,077	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,949,293	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	16,563,335	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,708,271	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,215,385	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	110,088,963	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	28,315,443	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	72,518,351	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	143,572,843	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,890,399	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	40,430,889	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,622,213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,200,644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,206,688	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,532,765	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	923,324	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	23,240,973	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,686,879	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,515,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	152,966,052	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,471,203	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	22,277,687	0.000000	90.00
91.00	09100	EMERGENCY	0	752,201	752,201	62,988,278	0.011942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	29,947,191	0.000000	92.00
200.00		Total (lines 50 through 199)	0	752,201	752,201	1,111,006,547		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
50.01	05001 ENDOSCOPY	0.000000	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	7,114	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	6,998	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	12,998	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	26,524	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,212	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	140,395	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	13,093	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	445	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	6,091	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	3,316	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	20,435	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	92	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	323,642	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.011942	60,922	728	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,335	0	0	0	92.00
200.00	Total (lines 50 through 199)		626,612	728	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 5/30/2018 8:22 am		
Title XVIII				Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,401,790	166,627,825	0.008413	205,472	1,729	50.00
50.01	05001	ENDOSCOPY	43,490	19,475,289	0.002233	24,135	54	50.01
51.00	05100	RECOVERY ROOM	317,331	10,706,556	0.029639	9,308	276	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,710	5,364,077	0.038350	1,398	54	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,643	36,949,293	0.030140	140,676	4,240	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	130,675	16,563,335	0.007889	39,707	313	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	283,540	13,708,271	0.020684	31,901	660	55.00
56.00	05600	RADIOISOTOPE	206,369	15,215,385	0.013563	11,025	150	56.00
57.00	05700	CT SCAN	265,027	110,088,963	0.002407	277,902	669	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	109,562	28,315,443	0.003869	93,736	363	58.00
59.00	05900	CARDIAC CATHETERIZATION	256,207	72,518,351	0.003533	135,507	479	59.00
60.00	06000	LABORATORY	684,916	143,572,843	0.004771	873,335	4,167	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,398	8,890,399	0.003419	56,685	194	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	213,056	40,430,889	0.005270	401,410	2,115	65.00
66.00	06600	PHYSICAL THERAPY	265,073	7,622,213	0.034776	2,294,548	79,795	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,958	6,200,644	0.035957	2,125,913	76,441	67.00
68.00	06800	SPEECH PATHOLOGY	42,185	2,206,688	0.019117	204,492	3,909	68.00
69.00	06900	ELECTROCARDIOLOGY	24,450	20,532,765	0.001191	26,226	31	69.00
69.01	06901	CARDIAC REHAB	6,306	923,324	0.006830	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	26,970	23,240,973	0.001160	20,171	23	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	468,284	49,686,879	0.009425	194,059	1,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	519,478	35,515,731	0.014627	8,574	125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,965	152,966,052	0.003654	3,868,095	14,134	73.00
74.00	07400	RENAL DIALYSIS	118,348	8,471,203	0.013971	437,855	6,117	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,556,856	22,277,687	0.069884	22,108	1,545	90.00
91.00	09100	EMERGENCY	767,233	62,988,278	0.012181	36	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	29,947,191	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	9,838,820	1,111,006,547		11,504,274	199,412	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	752,201	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	752,201	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	166,627,825	0.000000	50.00
50.01	05001	ENDOSCOPY	0	0	19,475,289	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	10,706,556	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,364,077	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	36,949,293	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	16,563,335	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	13,708,271	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	15,215,385	0.000000	56.00
57.00	05700	CT SCAN	0	0	110,088,963	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	28,315,443	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	72,518,351	0.000000	59.00
60.00	06000	LABORATORY	0	0	143,572,843	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	8,890,399	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	40,430,889	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,622,213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,200,644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,206,688	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	20,532,765	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	923,324	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	23,240,973	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	49,686,879	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	35,515,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	152,966,052	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	8,471,203	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	22,277,687	0.000000	90.00
91.00	09100	EMERGENCY	0	752,201	752,201	0.011942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	29,947,191	0.000000	92.00
200.00		Total (lines 50 through 199)	0	752,201	752,201	1,111,006,547	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/30/2018 8:22 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	205,472	0	0	0	50.00
50.01	05001 ENDOSCOPY	0.000000	24,135	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	9,308	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	1,398	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	140,676	0	1,761	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	39,707	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	31,901	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	11,025	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	277,902	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	93,736	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	135,507	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	873,335	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	56,685	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	401,410	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,294,548	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	2,125,913	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	204,492	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	26,226	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	20,171	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	194,059	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	8,574	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	3,868,095	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	437,855	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	22,108	0	0	0	90.00
91.00	09100 EMERGENCY	0.011942	36	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		11,504,274	0	1,761	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 8:22 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.088106	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0.204533	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0.264755	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.985324	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.237249	1,761	0	0	418	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0.179232	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.176397	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.188900	0	0	0	0	56.00
57.00 05700 CT SCAN	0.037392	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.051448	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.072545	0	0	0	0	59.00
60.00 06000 LABORATORY	0.113126	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.127735	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.404138	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.399363	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.367009	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.062598	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0.756398	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.076430	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.543466	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.151256	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.328059	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.483227	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.272922	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	0	0	0	0	92.00
200.00	Subtotal (see instructions)		1,761	0	418	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		1,761	0	418	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/30/2018 8:22 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
50.01 05001 ENDOSCOPY	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	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	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		90,715	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		90,715	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)		72,236	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		27,937	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		75,558,456	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		75,558,456	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)		75,558,456	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)		832.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		23,269,286	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)		23,269,286	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	13,539,584	8,536	1,586.17	3,570	5,662,627	43.00
43.01 NEONATAL ICU	3,429,065	2,820	1,215.98	0	0	43.01
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					33,694,744	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					62,626,657	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)					2,450,936	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,729,949	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					4,180,885	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					58,445,772	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)					18,479	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					832.92	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					15,391,529	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
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	7,191,384	75,558,456	0.095176	15,391,529	1,464,904	90.00
91.00	Nursing School cost	0	75,558,456	0.000000	15,391,529	0	91.00
92.00	Allied health cost	0	75,558,456	0.000000	15,391,529	0	92.00
93.00	All other Medical Education	0	75,558,456	0.000000	15,391,529	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,343	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,343	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)		2,343	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		925	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,870,885	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,870,885	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,870,885	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)		798.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		738,613	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)		738,613	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
		Component CCN: 15-S002				Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					97,046		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					835,659		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)					37,509		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,247		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					41,756		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					793,903		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	95,005	1,870,885	0.050781	0	0	90.00
91.00	Nursing School cost	0	1,870,885	0.000000	0	0	91.00
92.00	Allied health cost	0	1,870,885	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,870,885	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,525	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,525	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)		9,525	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,800	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,399,465	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,399,465	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)		7,399,465	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)		776.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,505,730	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,505,730	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
		Component CCN: 15-T002				Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,929,557		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,435,287		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)					432,680		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					199,412		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					632,092		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,803,195		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	710,606	7,399,465	0.096035	0	0	90.00
91.00	Nursing School cost	0	7,399,465	0.000000	0	0	91.00
92.00	Allied health cost	0	7,399,465	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,399,465	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			90,715 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			90,715 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)			72,236 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,165 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			2,849 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			75,558,456 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			75,558,456 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)			75,558,456 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)			832.92 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,636,192 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)			2,636,192 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description			Title XIX		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,646,170	2,849	928.81	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,539,584	8,536	1,586.17	0	43.00
43.01	NEONATAL ICU	3,429,065	2,820	1,215.98	0	43.01
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,944,423	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				4,580,615	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 anesthesiologist, 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)				18,479	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				832.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				15,391,529	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
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	7,191,384	75,558,456	0.095176	15,391,529	1,464,904	90.00
91.00	Nursing School cost	0	75,558,456	0.000000	15,391,529	0	91.00
92.00	Allied health cost	0	75,558,456	0.000000	15,391,529	0	92.00
93.00	All other Medical Education	0	75,558,456	0.000000	15,391,529	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Component CCN: 15-S002		Date/Time Prepared: 5/30/2018 8:22 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,343	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,343	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)		2,343	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		619	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,849	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,870,885	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,870,885	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,870,885	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)		798.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		494,272	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)		494,272	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1	
				Component CCN: 15-S002		Date/Time Prepared: 5/30/2018 8:22 am	
				Title XIX	Subprovider - IPF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,519		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					501,791		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	95,005	1,870,885	0.050781	0	0	90.00
91.00	Nursing School cost	0	1,870,885	0.000000	0	0	91.00
92.00	Allied health cost	0	1,870,885	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,870,885	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Component CCN: 15-T002		Date/Time Prepared: 5/30/2018 8:22 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,525	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,525	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)		9,525	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		88	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		2,849	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,399,465	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,399,465	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)		7,399,465	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)		776.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		68,363	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)		68,363	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1	
				Component CCN: 15-T002		Date/Time Prepared: 5/30/2018 8:22 am	
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					50,397		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					118,760		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	710,606	7,399,465	0.096035	0	0	90.00
91.00	Nursing School cost	0	7,399,465	0.000000	0	0	91.00
92.00	Allied health cost	0	7,399,465	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,399,465	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		25,819,562	30.00
31.00	03100	INTENSIVE CARE UNIT		7,279,675	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.088106	34,173,838	50.00
50.01	05001	ENDOSCOPY	0.204533	1,781,266	50.01
51.00	05100	RECOVERY ROOM	0.264755	1,591,470	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.985324	120,037	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237249	4,413,398	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.179232	2,308,505	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177072	519,463	55.00
56.00	05600	RADIOISOTOPE	0.188900	2,290,286	56.00
57.00	05700	CT SCAN	0.037392	15,483,864	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051448	4,182,906	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.072545	14,826,580	59.00
60.00	06000	LABORATORY	0.113126	22,886,860	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	3,065,508	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.127735	13,168,276	65.00
66.00	06600	PHYSICAL THERAPY	0.404138	1,627,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.399363	1,123,450	67.00
68.00	06800	SPEECH PATHOLOGY	0.367009	735,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062598	5,113,000	69.00
69.01	06901	CARDIAC REHAB	0.756398	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076430	3,024,434	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	8,337,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.543466	8,528,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151256	41,222,169	73.00
74.00	07400	RENAL DIALYSIS	0.328059	3,611,201	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.484588	207,360	90.00
91.00	09100	EMERGENCY	0.273160	8,995,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	2,906,907	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		206,245,767	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)		206,245,767	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		1,368,929	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.088106	0	50.00
50.01	05001	ENDOSCOPY	0.204533	0	50.01
51.00	05100	RECOVERY ROOM	0.264755	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.985324	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237249	7,114	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.179232	6,998	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177072	0	55.00
56.00	05600	RADIOISOTOPE	0.188900	12,998	56.00
57.00	05700	CT SCAN	0.037392	26,524	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051448	3,212	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.072545	0	59.00
60.00	06000	LABORATORY	0.113126	140,395	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	13,093	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.127735	445	65.00
66.00	06600	PHYSICAL THERAPY	0.404138	6,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.399363	3,316	67.00
68.00	06800	SPEECH PATHOLOGY	0.367009	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062598	20,435	69.00
69.01	06901	CARDIAC REHAB	0.756398	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076430	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	92	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.543466	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151256	323,642	73.00
74.00	07400	RENAL DIALYSIS	0.328059	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.484588	0	90.00
91.00	09100	EMERGENCY	0.273160	60,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	1,335	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		626,612	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)		626,612	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		44	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		4,808,076	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.088106	205,472	50.00
50.01	05001	ENDOSCOPY	0.204533	24,135	50.01
51.00	05100	RECOVERY ROOM	0.264755	9,308	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.985324	1,398	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237249	140,676	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.179232	39,707	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177072	31,901	55.00
56.00	05600	RADIOISOTOPE	0.188900	11,025	56.00
57.00	05700	CT SCAN	0.037392	277,902	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051448	93,736	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.072545	135,507	59.00
60.00	06000	LABORATORY	0.113126	873,335	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	56,685	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.127735	401,410	65.00
66.00	06600	PHYSICAL THERAPY	0.404138	2,294,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.399363	2,125,913	67.00
68.00	06800	SPEECH PATHOLOGY	0.367009	204,492	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062598	26,226	69.00
69.01	06901	CARDIAC REHAB	0.756398	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076430	20,171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	194,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.543466	8,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151256	3,868,095	73.00
74.00	07400	RENAL DIALYSIS	0.328059	437,855	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.484588	22,108	90.00
91.00	09100	EMERGENCY	0.273160	36	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,504,274	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)		11,504,274	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 8:22 am	
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		1,891,793	30.00
31.00	03100	INTENSIVE CARE UNIT		392,077	31.00
31.01	03101	NEONATAL ICU		500,784	31.01
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		185,315	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.088106	3,228,210	284,425 50.00
50.01	05001	ENDOSCOPY	0.204533	83,238	17,025 50.01
51.00	05100	RECOVERY ROOM	0.264755	163,559	43,303 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.985324	340,975	335,971 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237249	212,609	50,441 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.179232	131,216	23,518 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176397	35,187	6,207 55.00
56.00	05600	RADIOISOTOPE	0.188900	103,907	19,628 56.00
57.00	05700	CT SCAN	0.037392	909,413	34,005 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051448	208,793	10,742 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.072545	986,414	71,559 59.00
60.00	06000	LABORATORY	0.113126	1,668,979	188,805 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	31,289	7,591 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.127735	965,648	123,347 65.00
66.00	06600	PHYSICAL THERAPY	0.404138	100,369	40,563 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.399363	75,878	30,303 67.00
68.00	06800	SPEECH PATHOLOGY	0.367009	30,991	11,374 68.00
69.00	06900	ELECTROCARDIOLOGY	0.062598	228,643	14,313 69.00
69.01	06901	CARDIAC REHAB	0.756398	3,519	2,662 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076430	200,148	15,297 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.543466	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151256	2,685,751	406,236 73.00
74.00	07400	RENAL DIALYSIS	0.328059	152,590	50,059 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.483227	12,472	6,027 90.00
91.00	09100	EMERGENCY	0.272922	553,352	151,022 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,113,150	1,944,423 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		13,113,150	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 8:22 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	03101 NEONATAL ICU		0		31.01
40.00	04000 SUBPROVIDER - I PF		88,557		40.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.088106	0	0	50.00
50.01	05001 ENDOSCOPY	0.204533	0	0	50.01
51.00	05100 RECOVERY ROOM	0.264755	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.985324	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237249	1,056	251	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.179232	1,016	182	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.176397	0	0	55.00
56.00	05600 RADIOISOTOPE	0.188900	0	0	56.00
57.00	05700 CT SCAN	0.037392	2,312	86	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.051448	353	18	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.072545	0	0	59.00
60.00	06000 LABORATORY	0.113126	11,956	1,353	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.127735	1,682	215	65.00
66.00	06600 PHYSICAL THERAPY	0.404138	238	96	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.399363	139	56	67.00
68.00	06800 SPEECH PATHOLOGY	0.367009	42	15	68.00
69.00	06900 ELECTROCARDIOLOGY	0.062598	1,074	67	69.00
69.01	06901 CARDIAC REHAB	0.756398	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.076430	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	41	14	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.543466	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151256	26,774	4,050	73.00
74.00	07400 RENAL DIALYSIS	0.328059	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.483227	0	0	90.00
91.00	09100 EMERGENCY	0.272922	4,090	1,116	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		50,773	7,519	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		50,773		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	03101 NEONATAL ICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		80,551		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.088106	1,397	123	50.00
50.01	05001 ENDOSCOPY	0.204533	523	107	50.01
51.00	05100 RECOVERY ROOM	0.264755	456	121	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.985324	999	984	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237249	1,913	454	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.179232	481	86	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.176397	0	0	55.00
56.00	05600 RADIOISOTOPE	0.188900	252	48	56.00
57.00	05700 CT SCAN	0.037392	1,740	65	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.051448	1,843	95	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.072545	0	0	59.00
60.00	06000 LABORATORY	0.113126	12,393	1,402	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.242607	153	37	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.127735	8,070	1,031	65.00
66.00	06600 PHYSICAL THERAPY	0.404138	40,277	16,277	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.399363	35,559	14,201	67.00
68.00	06800 SPEECH PATHOLOGY	0.367009	5,309	1,948	68.00
69.00	06900 ELECTROCARDIOLOGY	0.062598	777	49	69.00
69.01	06901 CARDIAC REHAB	0.756398	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.076430	343	26	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.344888	1,861	642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.543466	171	93	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151256	71,675	10,841	73.00
74.00	07400 RENAL DIALYSIS	0.328059	5,386	1,767	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.483227	0	0	90.00
91.00	09100 EMERGENCY	0.272922	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.513956	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		191,578	50,397	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		191,578	50,397	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		35,049,700	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,235,752	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,725,159	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		18,375,817	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		394.37	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		8.53	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		8.53	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.93	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		2.93	12.00
13.00	Total allowable FTE count for the prior year.		2.93	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		3.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.95	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		2.95	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.007480	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.007610	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.007480	21.00
22.00	IME payment adjustment (see instructions)		188,891	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		74,992	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-5.60	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		188,891	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		74,992	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		10.92	30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.51	31.00
32.00	Sum of lines 30 and 31		42.43	32.00
33.00	Allowable disproportionate share percentage (see instructions)		24.22	33.00
34.00	Disproportionate share adjustment (see instructions)		2,802,584	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,163	35.00
35.01	Factor 3 (see instructions)	0.000846433	0.000831454	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	5,059,538	5,626,195	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	3,784,256	1,418,111	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,202,367		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	6,856		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	672		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	672		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	9.80		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	4,755		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	1.010842		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	447.81		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	56,204,453		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		56,279,445	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,108,515	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		84,695	52.00
53.00	Nursing and Allied Health Managed Care payment		18,229	53.00
54.00	Special add-on payments for new technologies		14,194	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		107,420	58.00
59.00	Total (sum of amounts on lines 49 through 58)		60,612,498	59.00
60.00	Primary payer payments		4,613	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		60,607,885	61.00
62.00	Deductibles billed to program beneficiaries		4,444,888	62.00
63.00	Coinurance billed to program beneficiaries		620,165	63.00
64.00	Allowable bad debts (see instructions)		1,594,781	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		1,036,608	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		574,875	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		56,579,440	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		255,837	70.93
70.94	HRR adjustment amount (see instructions)		-1,079,866	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			55,755,411	71.00
71.01	Sequestration adjustment (see instructions)			1,115,108	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			53,490,392	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			1,149,911	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			967,832	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2018 8:22 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	35,049,700	0	35,049,700	35,049,700	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,235,752	0	11,235,752	11,235,752	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	1,725,159	0	1,308,014	417,145	2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	18,375,817	0	14,352,230	4,023,587	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007480	0.007480	0.007480	0.007480	5.00	
6.00	IME payment adjustment (see instructions)	22.00	188,891	0	143,038	45,853	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	74,992	0	74,992	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	188,891	0	143,038	45,853	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	74,992	0	74,992	0	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2422	0.2422	0.2422	0.2422	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	2,802,584	0	2,122,259	680,325	11.00	
11.01	Uncompensated care payments	36.00	5,202,367	0	3,784,256	1,418,111	11.01	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	56,204,453	0	42,407,267	13,797,186	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	56,279,445	0	42,482,259	13,797,186	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	4,108,515	0	3,105,838	1,002,677	16.00	
17.00	Special add-on payments for new technologies	54.00	14,194	0	14,194	0	17.00	
17.01	Net organ acquisition cost						17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2018 8:22 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	45,602,291	14,799,863	60,402,154	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	3,752,656	0	2,837,397	915,259	3,752,656	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,736	0	3,712	2,024	5,736	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0036	0.0036	0.0036	0.0036		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	13,510	0	10,215	3,295	13,510	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0897	0.0897	0.0897	0.0897		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	336,613	0	254,514	82,099	336,613	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,108,515	0	3,105,838	1,002,677	4,108,515	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2018 8:22 am	
Title XVIII				Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	35,049,700	35,049,700		35,049,700	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,235,752		11,235,752	11,235,752	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,725,159	1,308,014	417,145	1,725,159	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	18,375,817	14,352,230	4,023,587	18,375,817	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007480	0.007480	0.007480		5.00
6.00	IME payment adjustment (see instructions)	22.00	188,891	143,038	45,853	188,891	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	74,992	58,572	16,420	74,992	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	188,891	143,038	45,853	188,891	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	74,992	58,572	16,420	74,992	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2422	0.2422	0.2422		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,802,584	2,122,259	680,325	2,802,584	11.00
11.01	Uncompensated care payments	36.00	5,202,367	3,784,256	1,418,111	5,202,367	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	56,204,453	42,407,267	13,797,186	56,204,453	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	56,279,445	42,465,839	13,813,606	56,279,445	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	4,108,515	3,105,838	1,002,677	4,108,515	16.00
17.00	Special add-on payments for new technologies	54.00	14,194	14,194	0	14,194	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			45,585,871	14,816,283	60,402,154	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002		Period: From 01/01/2017 To 12/31/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,752,656	2,837,397	915,259	3,752,656	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,736	3,712	2,024	5,736	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0036	0.0036	0.0036		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	13,510	10,215	3,295	13,510	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0897	0.0897	0.0897		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	336,613	254,514	82,099	336,613	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,108,515	3,105,838	1,002,677	4,108,515	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	255,837	253,647	2,190	255,837	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,079,866	-845,038	-234,828	-1,079,866	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		15,606	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		20,863,761	2.00
3.00	OPPTS payments		19,678,028	3.00
4.00	Outlier payment (see instructions)		180,213	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		96,286	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		15,606	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		82,028	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)		82,028	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		82,028	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		66,422	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)		15,606	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)		19,954,527	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,632,665	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		16,337,468	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		25,049	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		16,362,517	30.00
31.00	Primary payer payments		9,460	31.00
32.00	Subtotal (line 30 minus line 31)		16,353,057	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,438,348	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		934,926	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		855,814	36.00
37.00	Subtotal (see instructions)		17,287,983	37.00
38.00	MSP-LCC reconciliation amount from PS&R		1,115	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		17,286,868	40.00
40.01	Sequestration adjustment (see instructions)		345,737	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		16,803,008	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		138,123	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		418	2.00
3.00	OPPS payments		116	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		116	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		23	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)		93	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)		93	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		93	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		93	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)		93	40.00
40.01	Sequestration adjustment (see instructions)		2	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		91	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0002

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2018 8:22 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		52,406,516		15,893,138	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/31/2017	1,083,876	12/31/2017	909,870	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)		1,083,876		909,870	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)		53,490,392		16,803,008	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		1,149,911		138,123	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		54,640,303		16,941,131	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2017 To 12/31/2017		Worksheet E-1 Part I Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		660,270		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)		660,270		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		43,184		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		703,454		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				91 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		7,705,194		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)				0 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)		7,705,194		91 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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		68,365		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		7,773,559		91 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			762,498 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			6.419178 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			762,498 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			762,498 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			762,498 18.00
19.00	Deductibles			51,324 19.00
20.00	Subtotal (line 18 minus line 19)			711,174 20.00
21.00	Coinsurance			37,422 21.00
22.00	Subtotal (line 20 minus line 21)			673,752 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			66,661 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			43,330 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			9,212 25.00
26.00	Subtotal (sum of lines 22 and 24)			717,082 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			728 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			717,810 31.00
31.01	Sequestration adjustment (see instructions)			14,356 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			660,270 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			43,184 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			7,212,887 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0956 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			415,462 3.00
4.00	Outlier Payments			361,280 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			26.095890 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			7,989,629 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			7,989,629 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			7,989,629 19.00
20.00	Deductibles			23,688 20.00
21.00	Subtotal (line 19 minus line 20)			7,965,941 21.00
22.00	Coinurance			75,341 22.00
23.00	Subtotal (line 21 minus line 22)			7,890,600 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			64,004 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			41,603 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			48,437 26.00
27.00	Subtotal (sum of lines 23 and 25)			7,932,203 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			7,932,203 32.00
32.01	Sequestration adjustment (see instructions)			158,644 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			7,705,194 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			68,365 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			202,683 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			361,280 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 8:22 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,580,615		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,580,615	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4,580,615	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,969,968		8.00
9.00	Ancillary service charges		13,113,150	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		16,083,118	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		16,083,118	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		11,502,503	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		4,580,615	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,580,615	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,580,615	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,580,615	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,580,615	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,580,615	0	40.00
41.00	Interim payments		5,060,197	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-479,582	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 8:22 am
		Title XIX	Subprovider - IPF	Cost
			Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services		501,791	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		501,791	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		501,791	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		88,557	8.00
9.00	Ancillary service charges		50,773	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		139,330	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000
16.00	Total customary charges (see instructions)		139,330	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		362,461	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		139,330	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		139,330	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		362,461	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		139,330	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		139,330	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		139,330	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		139,330	40.00
41.00	Interim payments		43,837	41.00
42.00	Balance due provider/program (line 40 minus line 41)		95,493	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 8:22 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services	118,760		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	118,760	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	118,760	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	80,551		8.00
9.00	Ancillary service charges	191,578	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	272,129	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	272,129	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	153,369	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	118,760	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	118,760	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	118,760	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	118,760	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	118,760	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	118,760	0	40.00
41.00	Interim payments	85,620	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	33,140	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/30/2018 8:22 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			10.93	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			10.93	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.93	6.00
7.00	Enter the lesser of line 5 or line 6			2.93	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.43	2.43	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.43	2.43	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.43		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.53		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.42		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.46		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	2.46		17.00
18.00	Per resident amount	0.00	83,086.53		18.00
19.00	Approved amount for resident costs	0	204,393	204,393	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			204,393	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	38,232	15,232		26.00
27.00	Total Inpatient Days (see instructions)	95,566	95,566		27.00
28.00	Ratio of inpatient days to total inpatient days	0.400059	0.159387		28.00
29.00	Program direct GME amount	81,769	32,578		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		4,603		30.00
31.00	Net Program direct GME amount			109,744	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		8,471,203	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		70,897,603	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		4,613	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		70,892,990	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		20,976,071	42.00
43.00	Primary payer payments (see instructions)		9,460	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		20,966,611	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		91,859,601	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.771754	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.228246	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		109,744	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		84,695	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		25,049	50.00

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

Provider CCN: 15-0002

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

Worksheet G

Date/Time Prepared:
5/30/2018 8:22 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	1,374,997	0	0	0	1.00
2.00	Temporary investments	576,070	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	73,771,381	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-25,130,009	0	0	0	6.00
7.00	Inventory	11,403,205	0	0	0	7.00
8.00	Prepaid expenses	3,616,215	0	0	0	8.00
9.00	Other current assets	23,882,494	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)	89,494,353	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,373,674	0	0	0	12.00
13.00	Land improvements	6,652,126	0	0	0	13.00
14.00	Accumulated depreciation	-347,669,702	0	0	0	14.00
15.00	Buildings	273,095,783	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,606,826	0	0	0	17.00
18.00	Accumulated depreciation	0	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	204,660,944	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	144,719,651	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	129,402,882	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	129,402,882	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	363,616,886	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,309,117	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,436,521	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	25,015,358	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	38,760,996	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	61,519,536	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,995,639	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	82,515,175	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	121,276,171	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	242,340,715				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)	242,340,715	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	363,616,886	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0002

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

Worksheet G-1

Date/Time Prepared:
5/30/2018 8:22 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		243,458,347		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,435,424				2.00
3.00	Total (sum of line 1 and line 2)		251,893,771		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		251,893,771		0		11.00
12.00	RECONCILING ENTITIES	9,553,056		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		9,553,056		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		242,340,715		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	RECONCILING ENTITIES		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0002

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2018 8:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	71,361,211		71,361,211	1.00
2.00	SUBPROVIDER - IPF	3,462,684		3,462,684	2.00
3.00	SUBPROVIDER - IRF	7,909,819		7,909,819	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)	82,733,714		82,733,714	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,214,273		23,214,273	11.00
11.01	NEONATAL ICU	0		0	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	23,214,273		23,214,273	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	105,947,987		105,947,987	17.00
18.00	Ancillary services	521,089,136	474,704,253	995,793,389	18.00
19.00	Outpatient services	23,330,660	91,882,497	115,213,157	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		3,342,486	3,342,486	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 PROFESSIONAL FEES	532,713	55,828,785	56,361,498	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	650,900,496	625,758,021	1,276,658,517	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		342,976,851		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)		342,976,851		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/30/2018 8:22 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,276,658,517	1.00
2.00	Less contractual allowances and discounts on patients' accounts	986,304,338	2.00
3.00	Net patient revenues (line 1 minus line 2)	290,354,179	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	342,976,851	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-52,622,672	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	INVESTMENT INCOME	6,470,253	24.00
24.01	NON OPERATING INCOME	32,083	24.01
24.02	CHANGE IN UNREALIZED GAIN/LOSS	2,620,238	24.02
24.03	REALIZED GAIN/LOSS ON INVESTMENT SAL	9,475,491	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL	158,516	24.04
24.05	OTHER INCOME	4,118,796	24.05
24.06	DSH	38,395,879	24.06
25.00	Total other income (sum of lines 6-24)	61,271,256	25.00
26.00	Total (line 5 plus line 25)	8,648,584	26.00
27.00	LOSS ON SALE OF EQUIPMENT	213,160	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	213,160	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,435,424	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0002

Period: From 01/01/2017

Worksheet H

HHA CCN: 15-7536

To 12/31/2017

Date/Time Prepared: 5/30/2018 8:22 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	428,107	0	0	348,334	776,441	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	889,760	0	0	0	889,760	6.00
7.00	Physical Therapy	457,230	0	0	0	457,230	7.00
8.00	Occupational Therapy	114,021	0	0	0	114,021	8.00
9.00	Speech Pathology	48,784	0	0	0	48,784	9.00
10.00	Medical Social Services	3,200	0	0	0	3,200	10.00
11.00	Home Health Aide	71,684	0	0	0	71,684	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,012,786	0	0	348,334	2,361,120	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-6,828	769,613	0	769,613		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	889,760	0	889,760		6.00
7.00	Physical Therapy	0	457,230	0	457,230		7.00
8.00	Occupational Therapy	0	114,021	0	114,021		8.00
9.00	Speech Pathology	0	48,784	0	48,784		9.00
10.00	Medical Social Services	0	3,200	0	3,200		10.00
11.00	Home Health Aide	0	71,684	0	71,684		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-6,828	2,354,292	0	2,354,292		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2017 To 12/31/2017		Worksheet H-1 Part I Date/Time Prepared: 5/30/2018 8:22 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	769,613	0	0	0	769,613	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	889,760	0	0	0	889,760	6.00
7.00	Physical Therapy	457,230	0	0	0	457,230	7.00
8.00	Occupational Therapy	114,021	0	0	0	114,021	8.00
9.00	Speech Pathology	48,784	0	0	0	48,784	9.00
10.00	Medical Social Services	3,200	0	0	0	3,200	10.00
11.00	Home Health Aide	71,684	0	0	0	71,684	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,354,292	0	0	0	2,354,292	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	769,613					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	432,120	1,321,880				6.00
7.00	Physical Therapy	222,058	679,288				7.00
8.00	Occupational Therapy	55,375	169,396				8.00
9.00	Speech Pathology	23,692	72,476				9.00
10.00	Medical Social Services	1,554	4,754				10.00
11.00	Home Health Aide	34,814	106,498				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		2,354,292				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2017 To 12/31/2017		Worksheet H-1 Part II Date/Time Prepared: 5/30/2018 8:22 am	
				Home Health Agency I		PPS	
	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-769,613	1,584,679
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	889,760
7.00	Physical Therapy	0	0	0	0	0	457,230
8.00	Occupational Therapy	0	0	0	0	0	114,021
9.00	Speech Pathology	0	0	0	0	0	48,784
10.00	Medical Social Services	0	0	0	0	0	3,200
11.00	Home Health Aide	0	0	0	0	0	71,684
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-769,613	1,584,679
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		769,613
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.485659

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2017

Part I
Date/Time Prepared:
5/30/2018 8:22 am

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT					
	0	1.00	4.00	5.01	5.02	5.03	
1.00 Administrative and General	0	0	482,835	0	7,491	8,316	1.00
2.00 Skilled Nursing Care	1,321,880	0	0	0	0	0	2.00
3.00 Physical Therapy	679,288	0	0	0	0	0	3.00
4.00 Occupational Therapy	169,396	0	0	0	0	0	4.00
5.00 Speech Pathology	72,476	0	0	0	0	0	5.00
6.00 Medical Social Services	4,754	0	0	0	0	0	6.00
7.00 Home Health Aide	106,498	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,354,292	0	482,835	0	7,491	8,316	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	5.04	5A.04	5.05	5.06	7.00	8.00	
1.00 Administrative and General	14,677	513,319	57,477	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,321,880	148,014	0	0	0	2.00
3.00 Physical Therapy	0	679,288	76,061	0	0	0	3.00
4.00 Occupational Therapy	0	169,396	18,968	0	0	0	4.00
5.00 Speech Pathology	0	72,476	8,115	0	0	0	5.00
6.00 Medical Social Services	0	4,754	532	0	0	0	6.00
7.00 Home Health Aide	0	106,498	11,925	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	14,677	2,867,611	321,092	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2017

Part I Date/Time Prepared: 5/30/2018 8:22 am

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	4,984	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	4,984	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS	
		16.00	17.00	17.01	17.02	21.00	22.00	
1.00	Administrative and General	11,649	0	8,005	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	11,649	0	8,005	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2017

Part I
Date/Time Prepared:
5/30/2018 8:22 am

Home Health
Agency I

PPS

Cost Center Description	PARAMED ED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	23.00	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	595,434	0	595,434			1.00
2.00 Skilled Nursing Care	0	1,469,894	0	1,469,894	334,322	1,804,216	2.00
3.00 Physical Therapy	0	755,349	0	755,349	171,802	927,151	3.00
4.00 Occupational Therapy	0	188,364	0	188,364	42,843	231,207	4.00
5.00 Speech Pathology	0	80,591	0	80,591	18,330	98,921	5.00
6.00 Medical Social Services	0	5,286	0	5,286	1,202	6,488	6.00
7.00 Home Health Aide	0	118,423	0	118,423	26,935	145,358	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	3,213,341	0	3,213,341	595,434	3,213,341	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.227447		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Prepared: 5/30/2018 8:22 am
		Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0	2,012,787	0	0	85,950	3,342,486	3,342,486	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,012,787	0	0	85,950	3,342,486	3,342,486	20.00
21.00 Total cost to be allocated	0	482,835	0	0	7,491	8,316	14,677	21.00
22.00 Unit cost multiplier	0.000000	0.239884	0.000000	0.000000	0.087155	0.002488	0.004391	22.00
Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)		
	5A.05	5.05	5.06	7.00	8.00	9.00		
1.00 Administrative and General	0	513,319	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,321,880	0	0	0	0	0	2.00
3.00 Physical Therapy	0	679,288	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	169,396	0	0	0	0	0	4.00
5.00 Speech Pathology	0	72,476	0	0	0	0	0	5.00
6.00 Medical Social Services	0	4,754	0	0	0	0	0	6.00
7.00 Home Health Aide	0	106,498	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,867,611	0	0	0	0	0	20.00
21.00 Total cost to be allocated	0	321,092	0	0	0	0	0	21.00
22.00 Unit cost multiplier	0	0.111972	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Prepared: 5/30/2018 8:22 am
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	11,044	3,342,486	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	11,044	3,342,486	20.00
21.00	Total cost to be allocated	0	0	0	0	4,984	11,649	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.451286	0.003485	22.00

Cost Center Description		INTERNS & RESIDENTS						
		SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED PROGRAM (ASSIGNED TIME)	
		17.00	17.01	17.02	21.00	22.00	23.00	
1.00	Administrative and General	0	1,729	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,729	0	0	0	0	20.00
21.00	Total cost to be allocated	0	8,005	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	4.629844	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part I Date/Time Prepared: 5/30/2018 8:22 am
		HHA CCN: 15-7536		

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

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,804,216		1,804,216	12,057	149.64	1.00
2.00	Physical Therapy	3.00	927,151	0	927,151	5,082	182.44	2.00
3.00	Occupational Therapy	4.00	231,207	0	231,207	1,148	201.40	3.00
4.00	Speech Pathology	5.00	98,921	0	98,921	265	373.29	4.00
5.00	Medical Social Services	6.00	6,488		6,488	52	124.77	5.00
6.00	Home Health Aide	7.00	145,358		145,358	2,462	59.04	6.00
7.00	Total (sum of lines 1-6)		3,213,341	0	3,213,341	21,066		7.00

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

Limitation Cost Computation						
8.00	Skilled Nursing Care		23844	0	3,770	8.00
9.00	Physical Therapy		23844	0	2,109	9.00
10.00	Occupational Therapy		23844	0	517	10.00
11.00	Speech Pathology		23844	0	89	11.00
12.00	Medical Social Services		23844	0	16	12.00
13.00	Home Health Aide		23844	0	933	13.00
14.00	Total (sum of lines 8-13)			0	7,434	14.00

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

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

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,770		0	564,143	1.00
2.00	Physical Therapy	0	2,109		0	384,766	2.00
3.00	Occupational Therapy	0	517		0	104,124	3.00
4.00	Speech Pathology	0	89		0	33,223	4.00
5.00	Medical Social Services	0	16		0	1,996	5.00
6.00	Home Health Aide	0	933		0	55,084	6.00
7.00	Total (sum of lines 1-6)	0	7,434		0	1,143,336	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2017 To 12/31/2017		Worksheet H-3 Part I Date/Time Prepared: 5/30/2018 8:22 am		
		Title XVIII		Home Health Agency I		PPS		
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B			Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	564,143					1.00	
2.00	Physical Therapy	384,766					2.00	
3.00	Occupational Therapy	104,124					3.00	
4.00	Speech Pathology	33,223					4.00	
5.00	Medical Social Services	1,996					5.00	
6.00	Home Health Aide	55,084					6.00	
7.00	Total (sum of lines 1-6)	1,143,336					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part II Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.404138	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.399363	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.367009	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.344888	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.151256	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2017 To 12/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2018 8:22 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	999,887	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	52,945	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	28,936	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	23,226	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	16,829	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	645	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,122,468	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,122,468	24.00
25.00	Coinurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,122,468	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,122,468	29.00
30.00	OTHER	0	83	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,122,551	31.00
31.01	Sequestration adjustment (see instructions)	0	22,451	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,100,099	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2017 To 12/31/2017	Worksheet H-5 Date/Time Prepared: 5/30/2018 8:22 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,100,099	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,100,099	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,100,100	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0002	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/30/2018 8:22 am
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,752,656	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		5,736	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		229.31	3.00
4.00	Number of interns & residents (see instructions)		2.95	4.00
5.00	Indirect medical education percentage (see instructions)		0.36	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		13,510	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		10.92	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.51	8.00
9.00	Sum of lines 7 and 8		42.43	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.97	10.00
11.00	Disproportionate share adjustment (see instructions)		336,613	11.00
12.00	Total prospective capital payments (see instructions)		4,108,515	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00