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: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/31/2018 11:12 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2018 Time: 11:12 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER MEMORIAL HOSPITAL (15-0035) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	571,987	46,672	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	16,205	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	588,192	46,672	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:11 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 85 EAST US HIGHWAY 6	PO Box:			1.00
2.00	City: VALPARAISO	State: IN	Zip Code: 46383	County: PORTER	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PORTER MEMORIAL HOSPITAL	150035	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	PORTER REHAB UNIT	15T035	23844	5	01/01/2009	N	P	O	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									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: 1.00	To: 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)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,514	659	32	105	7,884	223	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.	12	38	0	0	182		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:11 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 11:11 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 11:11 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:11 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 11:11 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	822,786	711,325	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 11:11 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	08/23/2017	11/20/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2018 11:11 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		Y	Y	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.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/16/2018	Y	04/16/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 11:11 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N	12/31/2016	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 11:11 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.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 11:11 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	192	70,080	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)		192	70,080	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	14	5,110	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)		238	86,870	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	14	5,110		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						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)		252				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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 11:11 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	20,527	910	44,198			1.00
2.00	HMO and other (see instructions)	8,555	7,772				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	182				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)	20,527	910	44,198			7.00
8.00	INTENSIVE CARE UNIT	3,302	504	7,399			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	0	2,723			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		1,008	1,008			13.00
14.00	Total (see instructions)	23,829	2,422	55,328	0.00	1,435.69	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,810	50	2,800	0.00	15.32	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,451.01	27.00
28.00	Observation Bed Days		0	3,859			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	223	562			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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 11:11 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,464	1,585	11,755	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						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	4,464	1,585	11,755	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	153	13	251	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 11:11 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	86,827,629	0	86,827,629	3,018,096.00	28.77	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		257,916	0	257,916	1,664.00	155.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,049,819	0	1,049,819	31,860.00	32.95	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,047,798	0	3,047,798	44,906.00	67.87	11.00
12.00	Contract labor: Top level management and other management and administrative services		760,810	0	760,810	36,708.00	20.73	12.00
13.00	Contract labor: Physician-Part A - Administrative		543,921	0	543,921	3,831.00	141.98	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,912,751	0	8,912,751	261,863.00	34.04	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		24,716,660	0	24,716,660			17.00
18.00	Wage-related costs (other) (see instructions)		58,607	0	58,607			18.00
19.00	Excluded areas		354,099	0	354,099			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		24,702	0	24,702			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	291,472	0	291,472	8,066.00	36.14	26.00
27.00	Administrative & General	5.00	8,919,999	-195,284	8,724,715	347,819.00	25.08	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2018 11:11 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	
28.00	Administrative & General under contract (see inst.)		736,266	0	736,266	27,201.00	27.07	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,720,655	0	1,720,655	61,268.00	28.08	30.00
31.00	Laundry & Linen Service	8.00	132,366	0	132,366	9,172.00	14.43	31.00
32.00	Housekeeping	9.00	1,717,186	0	1,717,186	139,760.00	12.29	32.00
33.00	Housekeeping under contract (see instructions)		236,059	0	236,059	4,872.00	48.45	33.00
34.00	Dietary	10.00	2,004,664	-1,154,266	850,398	58,300.00	14.59	34.00
35.00	Dietary under contract (see instructions)		288,625	0	288,625	7,488.00	38.55	35.00
36.00	Cafeteria	11.00	0	1,154,266	1,154,266	79,133.00	14.59	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,547,574	195,284	3,742,858	93,416.00	40.07	38.00
39.00	Central Services and Supply	14.00	932,566	0	932,566	58,726.00	15.88	39.00
40.00	Pharmacy	15.00	2,763,292	0	2,763,292	58,291.00	47.41	40.00
41.00	Medical Records & Medical Records Library	16.00	698,987	0	698,987	37,113.00	18.83	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2018 11:11 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		88,088,579	0	88,088,579	3,057,657.00	28.81	1.00
2.00	Excluded area salaries (see instructions)		1,049,819	0	1,049,819	31,860.00	32.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)		87,038,760	0	87,038,760	3,025,797.00	28.77	3.00
4.00	Subtotal other wages & related costs (see inst.)		13,265,280	0	13,265,280	347,308.00	38.19	4.00
5.00	Subtotal wage-related costs (see inst.)		24,799,969	0	24,799,969	0.00	28.49	5.00
6.00	Total (sum of lines 3 thru 5)		125,104,009	0	125,104,009	3,373,105.00	37.09	6.00
7.00	Total overhead cost (see instructions)		23,989,711	0	23,989,711	990,625.00	24.22	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2018 11:11 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,588,099	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	14,345,195	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	303,785	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	62,616	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	424	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	228,899	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,085,122	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	5,027,191	17.00
18.00	Medicare Taxes - Employers Portion Only	1,175,714	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	186,870	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	91,546	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	25,095,461	24.00
	Part B - Other than Core Related Cost		
25.00	EMPLOYEE TRAVEL AND OTHER	58,607	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/31/2018 11:11 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,047,798	25,154,068	1.00
2.00	Hospital	3,047,798	25,154,068	2.00
3.00	Subprovider - IPF			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			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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/31/2018 11:11 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.130907	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	29,431,599	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	217,306,848	6.00
7.00	Medicaid cost (line 1 times line 6)	28,446,988	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	868	9.00
10.00	Stand-alone CHIP charges	8,557	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	1,120	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	252	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)	252	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)	11,437,807	468,936	11,906,743	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,497,289	468,936	1,966,225	21.00
22.00	Payments received from patients for amounts previously written off as charity care	4,316	6,961	11,277	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,492,973	461,975	1,954,948	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)	15,935,768	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	656,245	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,009,607	27.01
28.00	Non-Medicare bad debt expense (see instructions)	14,926,161	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,307,301	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,262,249	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,262,501	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,543,962	4,543,962	2,478,441	7,022,403	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,628,325	11,628,325	2,619,929	14,248,254	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	291,472	602,913	894,385	15,774,305	16,668,690	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919,999	73,581,935	82,501,934	-19,546,006	62,955,928	5.00
7.00	00700	OPERATION OF PLANT	1,720,655	7,051,383	8,772,038	-2,282	8,769,756	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	132,366	1,102,855	1,235,221	0	1,235,221	8.00
9.00	00900	HOUSEKEEPING	1,717,186	1,445,578	3,162,764	0	3,162,764	9.00
10.00	01000	DIETARY	2,004,664	1,042,184	3,046,848	-1,758,140	1,288,708	10.00
11.00	01100	CAFETERIA	0	0	0	1,749,195	1,749,195	11.00
13.00	01300	NURSING ADMINISTRATION	3,547,574	638,564	4,186,138	195,649	4,381,787	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	932,566	27,357,040	28,289,606	-26,573,965	1,715,641	14.00
15.00	01500	PHARMACY	2,763,292	21,025,011	23,788,303	-20,521,956	3,266,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	698,987	2,189,054	2,888,041	0	2,888,041	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,571,565	5,683,682	21,255,247	-76,158	21,179,089	30.00
31.00	03100	INTENSIVE CARE UNIT	5,308,964	2,268,626	7,577,590	-70,791	7,506,799	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,861,243	1,099,398	2,960,641	0	2,960,641	31.01
41.00	04100	SUBPROVIDER - IRF	1,049,819	298,036	1,347,855	-9,938	1,337,917	41.00
43.00	04300	NURSERY	843,637	115,330	958,967	0	958,967	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,555,523	6,552,657	13,108,180	2,651,417	15,759,597	50.00
51.00	05100	RECOVERY ROOM	2,049,123	339,863	2,388,986	-2,388,986	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,652,845	612,107	2,264,952	-652	2,264,300	52.00
53.00	05300	ANESTHESIOLOGY	0	2,570,825	2,570,825	0	2,570,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,020,555	1,920,966	6,941,521	3,277,484	10,219,005	54.00
54.01	05401	ULTRASOUND	532,384	109,608	641,992	-641,992	0	54.01
56.00	05600	RADIOISOTOPE	400,588	899,079	1,299,667	-1,299,667	0	56.00
57.00	05700	CT SCAN	653,376	250,921	904,297	-904,297	0	57.00
58.00	05800	MRI	237,386	198,267	435,653	-435,653	0	58.00
60.00	06000	LABORATORY	4,979,603	6,423,614	11,403,217	-411,220	10,991,997	60.00
65.00	06500	RESPIRATORY THERAPY	1,775,491	620,361	2,395,852	-147,214	2,248,638	65.00
66.00	06600	PHYSICAL THERAPY	1,793,824	181,932	1,975,756	0	1,975,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	631,605	46,454	678,059	0	678,059	67.00
68.00	06800	SPEECH PATHOLOGY	503,450	36,486	539,936	0	539,936	68.00
69.00	06900	ELECTROCARDIOLOGY	4,673,928	4,268,167	8,942,095	246,869	9,188,964	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,741,212	1,741,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,207,383	24,207,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,314	233,746	357,060	20,310,204	20,667,264	73.00
74.00	07400	RENAL DIALYSIS	0	663,231	663,231	0	663,231	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	333,006	63,730	396,736	-396,736	0	76.01
76.03	03951	WOUND CARE	715,561	707,970	1,423,531	-528	1,423,003	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,832,078	5,953,526	12,785,604	-65,907	12,719,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,827,629	194,327,386	281,155,015	0	281,155,015	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,062	2,062	0	2,062	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	86,827,629	194,329,448	281,157,077	0	281,157,077	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 11:11 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	1,830,202	8,852,605		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-499,577	13,748,677		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,533	16,663,157		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,991,536	50,964,392		5.00
7.00	00700	OPERATION OF PLANT	0	8,769,756		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,235,221		8.00
9.00	00900	HOUSEKEEPING	0	3,162,764		9.00
10.00	01000	DIETARY	0	1,288,708		10.00
11.00	01100	CAFETERIA	0	1,749,195		11.00
13.00	01300	NURSING ADMINISTRATION	-18,746	4,363,041		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,715,641		14.00
15.00	01500	PHARMACY	0	3,266,347		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,091	2,886,950		16.00
23.00	02300	ALLIED HEALTH	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,832,105	19,346,984		30.00
31.00	03100	INTENSIVE CARE UNIT	-917,277	6,589,522		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-800,400	2,160,241		31.01
41.00	04100	SUBPROVIDER - IRF	0	1,337,917		41.00
43.00	04300	NURSERY	0	958,967		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-171,994	15,587,603		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-203,436	2,060,864		52.00
53.00	05300	ANESTHESIOLOGY	-2,366,354	204,471		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,033	10,215,972		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	10,991,997		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,248,638		65.00
66.00	06600	PHYSICAL THERAPY	0	1,975,756		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	678,059		67.00
68.00	06800	SPEECH PATHOLOGY	0	539,936		68.00
69.00	06900	ELECTROCARDIOLOGY	-1,547,465	7,641,499		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,741,212		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,207,383		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,527	20,671,791		73.00
74.00	07400	RENAL DIALYSIS	0	663,231		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	1,423,003		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-4,033,362	8,686,335		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,557,180	258,597,835		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,062		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0		192.01
194.00	07950	NONREIMBURSABLE	0	0		194.00
194.01	07951	MARKETING	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0		194.03
194.04	07954	VACANT UNFINISHED AREA	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-22,557,180	258,599,897		200.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 11:11 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,774,305		1.00
	0		0	15,774,305		
	C - RENTAL AND LEASE EXPENSES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,514,430		1.00
2.00	NURSING ADMINISTRATION	13.00	0	365		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
	0		0	2,514,795		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	210,750		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,267,691		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	105,499		3.00
	0		0	2,583,940		
	F - CHIEF NURSING OFFICER COST					
1.00	NURSING ADMINISTRATION	13.00	195,284	0		1.00
	0		195,284	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,741,212		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	24,207,383		2.00
3.00	OPERATING ROOM	50.00	0	703,311		3.00
	0		0	26,651,906		
	H - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,310,204		1.00
	0		0	20,310,204		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	2,049,123	339,813		1.00
	0		2,049,123	339,813		
	L - OTHER RADIOLOGY COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,823,734	1,457,875		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
	0		1,823,734	1,457,875		
	M - DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	1,154,266	594,929		1.00
	0		1,154,266	594,929		
	O - SLEEP LAB COSTS TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	333,006	61,165		1.00
	0		333,006	61,165		
500.00	Grand Total: Increases		5,555,413	70,288,932		500.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 11:11 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,774,305	0		1.00
	0		0	15,774,305			
	C - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	992,477	10		1.00
2.00	OPERATION OF PLANT	7.00	0	2,282	0		2.00
3.00	DIETARY	10.00	0	8,945	0		3.00
4.00	SLEEP LAB	76.01	0	2,565	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	27,508	0		5.00
6.00	PHARMACY	15.00	0	211,752	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	76,158	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	70,791	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	9,938	0		9.00
10.00	OPERATING ROOM	50.00	0	440,830	0		10.00
11.00	LABORATORY	60.00	0	411,220	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	147,214	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	41,853	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	652	0		14.00
15.00	EMERGENCY	91.00	0	65,907	0		15.00
16.00	RECOVERY ROOM	51.00	0	50	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,125	0		17.00
18.00	WOUND CARE	76.03	0	528	0		18.00
	0		0	2,514,795			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,583,940	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	2,583,940			
	F - CHIEF NURSING OFFICER COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	195,284	0	0		1.00
	0		195,284	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,546,457	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	105,449	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	26,651,906			
	H - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	20,310,204	0		1.00
	0		0	20,310,204			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	2,049,123	339,813	0		1.00
	0		2,049,123	339,813			
	L - OTHER RADIOLOGY COST						
1.00	ULTRASOUND	54.01	532,384	109,608	0		1.00
2.00	RADIOISOTOPE	56.00	400,588	899,079	0		2.00
3.00	CT SCAN	57.00	653,376	250,921	0		3.00
4.00	MRI	58.00	237,386	198,267	0		4.00
	0		1,823,734	1,457,875			
	M - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	1,154,266	594,929	0		1.00
	0		1,154,266	594,929			
	O - SLEEP LAB COSTS TO EKG						
1.00	SLEEP LAB	76.01	333,006	61,165	0		1.00
	0		333,006	61,165			
500.00	Grand Total: Decreases		5,555,413	70,288,932			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2018 11:11 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,949,373	0	0	0	0	1.00
2.00	Land Improvements	3,504,286	0	0	0	0	2.00
3.00	Buildings and Fixtures	166,688,896	3,928	0	3,928	0	3.00
4.00	Building Improvements	5,359,943	192,300	0	192,300	7,900	4.00
5.00	Fixed Equipment	6,725,338	27,716	0	27,716	14,372	5.00
6.00	Movable Equipment	71,009,553	1,637,643	0	1,637,643	2,500,354	6.00
7.00	HIT designated Assets	17,919,748	0	0	0	104,193	7.00
8.00	Subtotal (sum of lines 1-7)	274,157,137	1,861,587	0	1,861,587	2,626,819	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	274,157,137	1,861,587	0	1,861,587	2,626,819	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,949,373	0	1.00
2.00	Land Improvements	3,504,286	0	2.00
3.00	Buildings and Fixtures	166,692,824	0	3.00
4.00	Building Improvements	5,544,343	0	4.00
5.00	Fixed Equipment	6,738,682	0	5.00
6.00	Movable Equipment	70,146,842	0	6.00
7.00	HIT designated Assets	17,815,555	0	7.00
8.00	Subtotal (sum of lines 1-7)	273,391,905	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	273,391,905	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2018 11:11 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	4,543,962	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,628,325	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	16,172,287	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	4,543,962		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,628,325		2.00
3.00	Total (sum of lines 1-2)	0	16,172,287		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2018 11:11 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	178,690,826	0	178,690,826	0.653607	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	94,701,079	0	94,701,079	0.346393	0	2.00
3.00	Total (sum of lines 1-2)	273,391,905	0	273,391,905	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,645,066	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,128,748	2,514,430	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,773,814	2,514,430	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	729,098	210,750	2,267,691	0	8,852,605	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	105,499	0	0	13,748,677	2.00
3.00	Total (sum of lines 1-2)	729,098	316,249	2,267,691	0	22,601,282	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 11:11 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-115,412	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-63,210	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-14,094,608			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,364,129			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	4,527	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,091	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	890,210	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,175,675	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-11,246	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 11:11 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC. NON PATIENT REVENUE	B	-20,216	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	NON-ALLOWABLE LEGAL FEES	A	-63,970	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONES WAGE COSTS	A	-19,098	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT PHONES BENEFITS COSTS	A	-5,533	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	PATIENT TV DEPRECIATION	A	-299	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING	A	-1,258,514	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITING	A	-640,942	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-13,831	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	CHARITABLE CONTRIBUTIONS	A	-105,804	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MEMBERSHIP DUES	A	-16,477	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MINORITY INTEREST	A	-3,308,269	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PATIENT PHONE DEPRECIATION	A	-86,160	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.14	PENALTIES	A	-1,591	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	FITNESS REVENUE	B	-1,389	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	SENIOR CIRCLE	A	-84,453	ADMINISTRATIVE & GENERAL	5.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,557,180				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 11:11 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	729,098	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	1,208,784	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS-BLDG & FI	82,103	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	128,791	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	802,813	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	7,444,275	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	1,534,111	1,907,555	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HIIM ALLOCATION	0	1,050,229	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	4,833,484	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,426,239	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	6,816	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	96,704	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	CONTRACT MANAGEMENT	0	114,948	4.09
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	32,608	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	2,264,620	4.15
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	1,563,535	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	274,731	4.18
4.21	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	3,800,883	2,546,472	4.21
4.22	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS-MOVEABLE	22,954	0	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,753,812	18,117,941	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 11:11 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	729,098	11		1.00
2.00	1,208,784	0		2.00
3.00	82,103	9		3.00
4.00	128,791	9		4.00
4.01	802,813	9		4.01
4.02	7,444,275	0		4.02
4.03	-373,444	0		4.03
4.04	-1,050,229	0		4.04
4.05	-4,833,484	11		4.05
4.06	-3,426,239	0		4.06
4.07	-6,816	0		4.07
4.08	-96,704	0		4.08
4.09	-114,948	0		4.09
4.14	-32,608	0		4.14
4.15	-2,264,620	0		4.15
4.17	-1,563,535	0		4.17
4.18	-274,731	0		4.18
4.21	1,254,411	0		4.21
4.22	22,954	9		4.22
5.00	-2,364,129			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2018 11:11 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	1,832,105	1,832,105	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	918,416	917,216	1,200	197,500	12	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	800,400	800,400	0	0	0	3.00
4.00	50.00	OPERATING ROOM	171,994	171,994	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,366,354	2,366,354	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	3,033	3,033	0	0	0	6.00
7.00	91.00	EMERGENCY	4,033,362	4,033,362	0	211,500	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	1,547,465	1,547,465	0	0	0	8.00
9.00	13.00	NURSING ADMINISTRATION	7,500	7,500	0	179,000	0	9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	2,211,682	2,211,682	0	0	0	10.00
11.00	52.00	DELIVERY ROOM & LABOR ROOM	203,436	203,436	0	0	0	11.00
200.00			14,095,747	14,094,547	1,200		12	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	31.00	INTENSIVE CARE UNIT	1,139	57	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	10.00
11.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	11.00
200.00			1,139	57	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	1,832,105		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	1,139	61	917,277		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	800,400		3.00
4.00	50.00	OPERATING ROOM	0	0	0	171,994		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,366,354		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,033		6.00
7.00	91.00	EMERGENCY	0	0	0	4,033,362		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,547,465		8.00
9.00	13.00	NURSING ADMINISTRATION	0	0	0	7,500		9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,211,682		10.00
11.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	203,436		11.00
200.00			0	1,139	61	14,094,608		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,852,605	8,852,605				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,748,677		13,748,677			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,663,157	28,034	45,821	16,737,012		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,964,392	390,339	638,002	1,687,456	53,680,189	5.00
7.00	00700	OPERATION OF PLANT	8,769,756	1,735,039	2,835,892	332,794	13,673,481	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,235,221	10,045	16,418	25,601	1,287,285	8.00
9.00	00900	HOUSEKEEPING	3,162,764	67,300	110,000	332,123	3,672,187	9.00
10.00	01000	DIETARY	1,288,708	204,894	334,895	164,476	1,992,973	10.00
11.00	01100	CAFETERIA	1,749,195	0	0	223,248	1,972,443	11.00
13.00	01300	NURSING ADMINISTRATION	4,363,041	99,747	163,034	723,910	5,349,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,715,641	142,354	232,675	180,369	2,271,039	14.00
15.00	01500	PHARMACY	3,266,347	78,091	127,638	534,451	4,006,527	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,886,950	26,899	43,966	135,192	3,093,007	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,346,984	1,175,251	1,920,926	3,011,679	25,454,840	30.00
31.00	03100	INTENSIVE CARE UNIT	6,589,522	204,778	334,707	1,026,812	8,155,819	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,160,241	79,163	129,390	359,985	2,728,779	31.01
41.00	04100	SUBPROVIDER - IRF	1,337,917	139,307	227,695	203,047	1,907,966	41.00
43.00	04300	NURSERY	958,967	25,102	41,029	163,169	1,188,267	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,587,603	688,402	1,125,180	1,664,233	19,065,418	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,060,864	137,016	223,951	319,678	2,741,509	52.00
53.00	05300	ANESTHESIOLOGY	204,471	11,884	19,424	0	235,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,215,972	496,369	811,306	1,323,761	12,847,408	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,991,997	186,023	304,051	963,110	12,445,181	60.00
65.00	06500	RESPIRATORY THERAPY	2,248,638	33,477	54,717	343,399	2,680,231	65.00
66.00	06600	PHYSICAL THERAPY	1,975,756	190,194	310,869	346,945	2,823,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	678,059	0	0	122,159	800,218	67.00
68.00	06800	SPEECH PATHOLOGY	539,936	0	0	97,373	637,309	68.00
69.00	06900	ELECTROCARDIOLOGY	7,641,499	316,398	517,147	968,396	9,443,440	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,741,212	0	0	0	1,741,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,207,383	0	0	0	24,207,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,671,791	0	0	23,850	20,695,641	73.00
74.00	07400	RENAL DIALYSIS	663,231	6,914	11,301	0	681,446	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	1,423,003	109,350	178,731	138,397	1,849,481	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,686,335	480,334	785,098	1,321,399	11,273,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,597,835	7,062,704	11,543,863	16,737,012	254,603,120	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,119	16,539	0	26,658	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,062	1,338,819	2,188,275	0	3,529,156	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	158,546	0	0	158,546	194.03
194.04	07954	VACANT UNFINISHED AREA	0	282,417	0	0	282,417	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	258,599,897	8,852,605	13,748,677	16,737,012	258,599,897	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,680,189					5.00
7.00	00700	OPERATION OF PLANT	3,581,864	17,255,345				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	337,213	26,999	1,651,497			8.00
9.00	00900	HOUSEKEEPING	961,955	180,886	0	4,815,028		9.00
10.00	01000	DIETARY	522,073	550,706	0	155,546	3,221,298	10.00
11.00	01100	CAFETERIA	516,695	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,401,400	268,095	0	75,723	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	594,915	382,614	9,166	108,069	0	14.00
15.00	01500	PHARMACY	1,049,538	209,890	8,724	59,283	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	810,235	72,298	0	20,420	0	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,668,111	3,158,794	679,035	892,196	1,854,567	30.00
31.00	03100	INTENSIVE CARE UNIT	2,136,474	550,395	154,783	155,458	146,345	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	714,823	212,770	12,611	60,097	23,628	31.01
41.00	04100	SUBPROVIDER - IRF	499,805	374,424	28,286	105,755	116,493	41.00
43.00	04300	NURSERY	311,275	67,469	8,913	19,056	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,994,320	1,850,260	138,919	522,603	3,700	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	718,157	368,267	46,488	104,016	26,309	52.00
53.00	05300	ANESTHESIOLOGY	61,764	31,941	0	9,022	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,365,468	1,334,121	160,306	376,820	1,059	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,260,102	499,985	189	141,220	0	60.00
65.00	06500	RESPIRATORY THERAPY	702,105	89,977	0	25,414	0	65.00
66.00	06600	PHYSICAL THERAPY	739,705	511,196	7,726	144,387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,623	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	166,948	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,473,775	850,403	98,950	240,195	26,453	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	456,123	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,341,293	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,421,368	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	178,510	18,583	0	5,249	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	484,484	293,908	6,873	83,014	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,953,085	1,291,025	290,528	364,648	45,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,633,206	13,195,006	1,651,497	3,668,191	2,244,503	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,983	27,196	0	7,682	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	924,487	3,598,424	0	1,016,369	486,567	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	8,585	0	2,425	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	41,532	426,134	0	120,361	490,228	194.03
194.04	07954	VACANT UNFINISHED AREA	73,981	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,680,189	17,255,345	1,651,497	4,815,028	3,221,298	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,489,138					11.00
13.00	01300	NURSING ADMINISTRATION	100,793	7,195,743				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,357	0	3,429,160			14.00
15.00	01500	PHARMACY	62,886	352,933	0	5,749,781		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,039	0	0	0	4,035,999	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	579,148	1,988,803	0	0	305,886	30.00
31.00	03100	INTENSIVE CARE UNIT	165,340	678,072	0	0	78,535	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	53,482	237,722	0	0	43,011	31.01
41.00	04100	SUBPROVIDER - IRF	34,383	134,085	0	0	16,226	41.00
43.00	04300	NURSERY	28,323	107,751	0	0	7,421	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	291,426	1,099,003	0	0	756,911	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,480	211,105	0	0	33,463	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	40,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	218,530	874,166	0	0	495,777	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	229,550	0	308,694	0	443,324	60.00
65.00	06500	RESPIRATORY THERAPY	62,908	0	0	0	93,599	65.00
66.00	06600	PHYSICAL THERAPY	56,939	0	0	0	43,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,224	0	0	0	21,938	67.00
68.00	06800	SPEECH PATHOLOGY	12,434	0	0	0	8,132	68.00
69.00	06900	ELECTROCARDIOLOGY	170,098	639,496	0	0	331,113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	174,009	0	92,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,946,457	0	370,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,244	0	0	5,749,781	422,471	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	7,678	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	23,812	0	0	0	27,012	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	219,742	872,607	0	0	397,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,489,138	7,195,743	3,429,160	5,749,781	4,035,999	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,489,138	7,195,743	3,429,160	5,749,781	4,035,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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
23.00	02300	ALLIED HEALTH	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	41,581,380	0	41,581,380		30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,221,221	0	12,221,221		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	4,086,923	0	4,086,923		31.01
41.00	04100	SUBPROVIDER - IRF	0	3,217,423	0	3,217,423		41.00
43.00	04300	NURSERY	0	1,738,475	0	1,738,475		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,722,560	0	28,722,560		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,304,794	0	4,304,794		52.00
53.00	05300	ANESTHESIOLOGY	0	378,981	0	378,981		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,673,655	0	19,673,655		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	17,328,245	0	17,328,245		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,654,234	0	3,654,234		65.00
66.00	06600	PHYSICAL THERAPY	0	4,326,966	0	4,326,966		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,050,003	0	1,050,003		67.00
68.00	06800	SPEECH PATHOLOGY	0	824,823	0	824,823		68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,273,923	0	14,273,923		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,463,649	0	2,463,649		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,865,458	0	33,865,458		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,291,505	0	32,291,505		73.00
74.00	07400	RENAL DIALYSIS	0	891,466	0	891,466		74.00
76.00	03950	ANCILLARY	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	2,768,584	0	2,768,584		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	17,707,898	0	17,707,898		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	247,372,166	0	247,372,166		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,519	0	68,519		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,555,003	0	9,555,003		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	11,010	0	11,010		192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	1,236,801	0	1,236,801		194.03
194.04	07954	VACANT UNFINISHED AREA	0	356,398	0	356,398		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	258,599,897	0	258,599,897		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	28,034	45,821	73,855	73,855	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	390,339	638,002	1,028,341	7,442	5.00
7.00	00700	OPERATION OF PLANT	0	1,735,039	2,835,892	4,570,931	1,468	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,045	16,418	26,463	113	8.00
9.00	00900	HOUSEKEEPING	0	67,300	110,000	177,300	1,465	9.00
10.00	01000	DIETARY	0	204,894	334,895	539,789	725	10.00
11.00	01100	CAFETERIA	0	0	0	0	985	11.00
13.00	01300	NURSING ADMINISTRATION	0	99,747	163,034	262,781	3,193	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	142,354	232,675	375,029	795	14.00
15.00	01500	PHARMACY	0	78,091	127,638	205,729	2,357	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,899	43,966	70,865	596	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,175,251	1,920,926	3,096,177	13,322	30.00
31.00	03100	INTENSIVE CARE UNIT	0	204,778	334,707	539,485	4,529	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	79,163	129,390	208,553	1,588	31.01
41.00	04100	SUBPROVIDER - IRF	0	139,307	227,695	367,002	895	41.00
43.00	04300	NURSERY	0	25,102	41,029	66,131	720	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	688,402	1,125,180	1,813,582	7,340	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	137,016	223,951	360,967	1,410	52.00
53.00	05300	ANESTHESIOLOGY	0	11,884	19,424	31,308	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	496,369	811,306	1,307,675	5,838	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	186,023	304,051	490,074	4,248	60.00
65.00	06500	RESPIRATORY THERAPY	0	33,477	54,717	88,194	1,514	65.00
66.00	06600	PHYSICAL THERAPY	0	190,194	310,869	501,063	1,530	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	539	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	429	68.00
69.00	06900	ELECTROCARDIOLOGY	0	316,398	517,147	833,545	4,271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	105	73.00
74.00	07400	RENAL DIALYSIS	0	6,914	11,301	18,215	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	109,350	178,731	288,081	610	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	480,334	785,098	1,265,432	5,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,062,704	11,543,863	18,606,567	73,855	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,119	16,539	26,658	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,338,819	2,188,275	3,527,094	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	158,546	0	158,546	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	282,417	0	282,417	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,852,605	13,748,677	22,601,282	73,855	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,035,783					5.00
7.00	00700	OPERATION OF PLANT	69,119	4,641,518				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,507	7,262	40,345			8.00
9.00	00900	HOUSEKEEPING	18,563	48,656	0	245,984		9.00
10.00	01000	DIETARY	10,074	148,135	0	7,946	706,669	10.00
11.00	01100	CAFETERIA	9,971	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	27,043	72,115	0	3,868	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,480	102,919	224	5,521	0	14.00
15.00	01500	PHARMACY	20,253	56,458	213	3,029	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,635	19,447	0	1,043	0	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	128,587	849,684	16,588	45,579	406,845	30.00
31.00	03100	INTENSIVE CARE UNIT	41,228	148,051	3,781	7,942	32,104	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	13,794	57,233	308	3,070	5,183	31.01
41.00	04100	SUBPROVIDER - IRF	9,645	100,716	691	5,403	25,556	41.00
43.00	04300	NURSERY	6,007	18,148	218	974	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,376	497,702	3,394	26,698	812	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,858	99,060	1,136	5,314	5,771	52.00
53.00	05300	ANESTHESIOLOGY	1,192	8,592	0	461	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,944	358,865	3,916	19,251	232	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	62,910	134,491	5	7,214	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,549	24,203	0	1,298	0	65.00
66.00	06600	PHYSICAL THERAPY	14,274	137,507	189	7,376	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,045	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,222	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	47,737	228,750	2,417	12,271	5,803	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,802	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122,368	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,616	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,445	4,999	0	268	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	9,349	79,058	168	4,241	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	56,986	347,273	7,097	18,629	10,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,015,579	3,549,324	40,345	187,396	492,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	135	7,316	0	392	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,840	967,943	0	51,923	106,740	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	2,309	0	124	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	801	114,626	0	6,149	107,543	194.03
194.04	07954	VACANT UNFINISHED AREA	1,428	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,035,783	4,641,518	40,345	245,984	706,669	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	10,956					11.00
13.00	01300	NURSING ADMINISTRATION	444	369,444				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	279	0	496,247			14.00
15.00	01500	PHARMACY	277	18,119	0	306,435		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	176	0	0	0	107,762	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,548	102,129	0	0	8,163	30.00
31.00	03100	INTENSIVE CARE UNIT	728	34,811	0	0	2,096	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	235	12,204	0	0	1,148	31.01
41.00	04100	SUBPROVIDER - IRF	151	6,884	0	0	433	41.00
43.00	04300	NURSERY	125	5,532	0	0	198	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,283	56,421	0	0	20,258	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	244	10,838	0	0	893	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962	44,878	0	0	13,230	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,010	0	44,673	0	11,830	60.00
65.00	06500	RESPIRATORY THERAPY	277	0	0	0	2,498	65.00
66.00	06600	PHYSICAL THERAPY	251	0	0	0	1,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	80	0	0	0	585	67.00
68.00	06800	SPEECH PATHOLOGY	55	0	0	0	217	68.00
69.00	06900	ELECTROCARDIOLOGY	749	32,830	0	0	8,836	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	25,182	0	2,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	426,392	0	9,882	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10	0	0	306,435	11,274	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	205	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	105	0	0	0	721	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	967	44,798	0	0	10,598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,956	369,444	496,247	306,435	107,762	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,956	369,444	496,247	306,435	107,762	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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
23.00	02300	ALLIED HEALTH	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,669,622	0	4,669,622		30.00
31.00	03100	INTENSIVE CARE UNIT		814,755	0	814,755		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		303,316	0	303,316		31.01
41.00	04100	SUBPROVIDER - IRF		517,376	0	517,376		41.00
43.00	04300	NURSERY		98,053	0	98,053		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,523,866	0	2,523,866		50.00
51.00	05100	RECOVERY ROOM		0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		499,491	0	499,491		52.00
53.00	05300	ANESTHESIOLOGY		42,633	0	42,633		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,819,791	0	1,819,791		54.00
54.01	05401	ULTRASOUND		0	0	0		54.01
56.00	05600	RADIOISOTOPE		0	0	0		56.00
57.00	05700	CT SCAN		0	0	0		57.00
58.00	05800	MRI		0	0	0		58.00
60.00	06000	LABORATORY		756,455	0	756,455		60.00
65.00	06500	RESPIRATORY THERAPY		131,533	0	131,533		65.00
66.00	06600	PHYSICAL THERAPY		663,344	0	663,344		66.00
67.00	06700	OCCUPATIONAL THERAPY		5,249	0	5,249		67.00
68.00	06800	SPEECH PATHOLOGY		3,923	0	3,923		68.00
69.00	06900	ELECTROCARDIOLOGY		1,177,209	0	1,177,209		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		36,447	0	36,447		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		558,642	0	558,642		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		422,440	0	422,440		73.00
74.00	07400	RENAL DIALYSIS		27,132	0	27,132		74.00
76.00	03950	ANCILLARY		0	0	0		76.00
76.01	03610	SLEEP LAB		0	0	0		76.01
76.03	03951	WOUND CARE		382,333	0	382,333		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		0	0	0		90.00
91.00	09100	EMERGENCY		1,767,688	0	1,767,688		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,221,298	0	17,221,298		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		34,501	0	34,501		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		4,671,540	0	4,671,540		192.00
192.01	19201	OTHER NONREIMBURSABLE		2,433	0	2,433		192.01
194.00	07950	NONREIMBURSABLE		0	0	0		194.00
194.01	07951	MARKETING		0	0	0		194.01
194.02	07952	SENIOR CIRCLE		0	0	0		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA		387,665	0	387,665		194.03
194.04	07954	VACANT UNFINISHED AREA		283,845	0	283,845		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	22,601,282	0	22,601,282		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	842,513					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		800,546				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,668	2,668	86,536,157			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,149	37,149	8,724,715	-53,680,189	204,919,708	5.00
7.00	00700	OPERATION OF PLANT	165,126	165,126	1,720,655	0	13,673,481	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	956	132,366	0	1,287,285	8.00
9.00	00900	HOUSEKEEPING	6,405	6,405	1,717,186	0	3,672,187	9.00
10.00	01000	DIETARY	19,500	19,500	850,398	0	1,992,973	10.00
11.00	01100	CAFETERIA	0	0	1,154,266	0	1,972,443	11.00
13.00	01300	NURSING ADMINISTRATION	9,493	9,493	3,742,858	0	5,349,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	13,548	932,566	0	2,271,039	14.00
15.00	01500	PHARMACY	7,432	7,432	2,763,292	0	4,006,527	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	2,560	698,987	0	3,093,007	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,850	111,850	15,571,565	0	25,454,840	30.00
31.00	03100	INTENSIVE CARE UNIT	19,489	19,489	5,308,964	0	8,155,819	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	7,534	1,861,243	0	2,728,779	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	13,258	1,049,819	0	1,907,966	41.00
43.00	04300	NURSERY	2,389	2,389	843,637	0	1,188,267	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	65,516	8,604,646	0	19,065,418	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	13,040	1,652,845	0	2,741,509	52.00
53.00	05300	ANESTHESIOLOGY	1,131	1,131	0	0	235,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,240	47,240	6,844,289	0	12,847,408	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,704	17,704	4,979,603	0	12,445,181	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	3,186	1,775,491	0	2,680,231	65.00
66.00	06600	PHYSICAL THERAPY	18,101	18,101	1,793,824	0	2,823,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	631,605	0	800,218	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	503,450	0	637,309	68.00
69.00	06900	ELECTROCARDIOLOGY	30,112	30,112	5,006,934	0	9,443,440	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,741,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	24,207,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	123,314	0	20,695,641	73.00
74.00	07400	RENAL DIALYSIS	658	658	0	0	681,446	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	10,407	10,407	715,561	0	1,849,481	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	45,714	45,714	6,832,078	0	11,273,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	672,166	672,166	86,536,157	-53,680,189	200,922,931	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	963	0	0	26,658	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,417	127,417	0	0	3,529,156	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	0	0	158,546	194.03
194.04	07954	VACANT UNFINISHED AREA	26,878	0	0	0	282,417	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,852,605	13,748,677	16,737,012		53,680,189	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.507381	17.174125	0.193411		0.261957	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			73,855		1,035,783	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000853		0.005055	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	610,996					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	2,152,212				8.00
9.00	00900	HOUSEKEEPING	6,405	0	603,635			9.00
10.00	01000	DIETARY	19,500	0	19,500	246,354		10.00
11.00	01100	CAFETERIA	0	0	0	0	110,908	11.00
13.00	01300	NURSING ADMINISTRATION	9,493	0	9,493	0	4,491	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	11,945	13,548	0	2,823	14.00
15.00	01500	PHARMACY	7,432	11,369	7,432	0	2,802	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	0	2,560	0	1,784	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,850	884,912	111,850	141,831	25,805	30.00
31.00	03100	INTENSIVE CARE UNIT	19,489	201,711	19,489	11,192	7,367	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	16,435	7,534	1,807	2,383	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	36,862	13,258	8,909	1,532	41.00
43.00	04300	NURSERY	2,389	11,615	2,389	0	1,262	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	181,038	65,516	283	12,985	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	60,582	13,040	2,012	2,472	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	1,131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,240	208,909	47,240	81	9,737	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,704	246	17,704	0	10,228	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	0	3,186	0	2,803	65.00
66.00	06600	PHYSICAL THERAPY	18,101	10,068	18,101	0	2,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	812	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	554	68.00
69.00	06900	ELECTROCARDIOLOGY	30,112	128,950	30,112	2,023	7,579	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	658	0	658	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	10,407	8,957	10,407	0	1,061	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	45,714	378,613	45,714	3,514	9,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	467,223	2,152,212	459,862	171,652	110,908	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,417	0	127,417	37,211	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	304	0	304	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	15,089	37,491	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	17,255,345	1,651,497	4,815,028	3,221,298	2,489,138	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.241339	0.767349	7.976721	13.075891	22.443268	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,641,518	40,345	245,984	706,669	10,956	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.596642	0.018746	0.407505	2.868510	0.098785	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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	56,339,313					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,515,571				14.00
15.00	01500	PHARMACY	2,763,292	0	20,533,044			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,889,682,306		16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,571,565	0	0	143,204,923	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,308,964	0	0	36,767,251	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,861,243	0	0	20,136,057	0	31.01
41.00	04100	SUBPROVIDER - IRF	1,049,819	0	0	7,596,480	0	41.00
43.00	04300	NURSERY	843,637	0	0	3,474,181	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,604,647	0	0	354,528,184	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,652,845	0	0	15,666,195	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,948,882	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,844,289	0	0	232,105,160	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,566,976	0	207,548,600	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	43,819,831	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,247,536	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,270,779	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,807,305	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,006,934	0	0	155,015,669	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,446,988	0	43,214,059	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,501,607	0	173,373,155	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,533,044	197,786,038	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,594,802	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	12,646,281	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,832,078	0	0	185,930,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,339,313	28,515,571	20,533,044	1,889,682,306	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,195,743	3,429,160	5,749,781	4,035,999	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.127722	0.120256	0.280026	0.002136	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	369,444	496,247	306,435	107,762	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006557	0.017403	0.014924	0.000057	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 11:11 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	23.00	
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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:11 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,581,380		41,581,380	0	41,581,380	30.00
31.00	03100	INTENSIVE CARE UNIT	12,221,221		12,221,221	61	12,221,282	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	4,086,923		4,086,923	0	4,086,923	31.01
41.00	04100	SUBPROVIDER - IRF	3,217,423		3,217,423	0	3,217,423	41.00
43.00	04300	NURSERY	1,738,475		1,738,475	0	1,738,475	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,722,560		28,722,560	0	28,722,560	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,304,794		4,304,794	0	4,304,794	52.00
53.00	05300	ANESTHESIOLOGY	378,981		378,981	0	378,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,673,655		19,673,655	0	19,673,655	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	17,328,245		17,328,245	0	17,328,245	60.00
65.00	06500	RESPIRATORY THERAPY	3,654,234	0	3,654,234	0	3,654,234	65.00
66.00	06600	PHYSICAL THERAPY	4,326,966	0	4,326,966	0	4,326,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,050,003	0	1,050,003	0	1,050,003	67.00
68.00	06800	SPEECH PATHOLOGY	824,823	0	824,823	0	824,823	68.00
69.00	06900	ELECTROCARDIOLOGY	14,273,923		14,273,923	0	14,273,923	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,463,649		2,463,649	0	2,463,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,865,458		33,865,458	0	33,865,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,291,505		32,291,505	0	32,291,505	73.00
74.00	07400	RENAL DIALYSIS	891,466		891,466	0	891,466	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,768,584		2,768,584	0	2,768,584	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	17,707,898		17,707,898	0	17,707,898	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,339,000		3,339,000		3,339,000	92.00
200.00		Subtotal (see instructions)	250,711,166	0	250,711,166	61	250,711,227	200.00
201.00		Less Observation Beds	3,339,000		3,339,000		3,339,000	201.00
202.00		Total (see instructions)	247,372,166	0	247,372,166	61	247,372,227	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	132,026,301		132,026,301			30.00
31.00	03100	INTENSIVE CARE UNIT	36,767,251		36,767,251			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	20,136,057		20,136,057			31.01
41.00	04100	SUBPROVIDER - IRF	7,596,480		7,596,480			41.00
43.00	04300	NURSERY	3,474,181		3,474,181			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,350,898	184,177,286	354,528,184	0.081016	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,988,631	677,564	15,666,195	0.274782	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,950,374	9,998,508	18,948,882	0.020000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,528,424	185,576,736	232,105,160	0.084762	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	83,204,628	124,343,972	207,548,600	0.083490	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	40,652,301	3,167,530	43,819,831	0.083392	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,054,523	7,193,013	20,247,536	0.213703	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,203,932	1,066,847	10,270,779	0.102232	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,756,000	1,051,305	3,807,305	0.216642	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	54,534,922	100,480,747	155,015,669	0.092081	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,831,189	18,382,870	43,214,059	0.057010	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,372,386	60,000,769	173,373,155	0.195333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,536,559	131,249,479	197,786,038	0.163265	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,514,987	79,815	3,594,802	0.247988	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	278,490	12,367,791	12,646,281	0.218925	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	47,547,856	138,383,082	185,930,938	0.095239	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,726,830	7,451,792	11,178,622	0.298695	0.000000	92.00
200.00		Subtotal (see instructions)	904,033,200	985,649,106	1,889,682,306			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	904,033,200	985,649,106	1,889,682,306			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:11 am

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
31.01	03101	NEONATAL INTENSIVE CARE UNIT	
41.00	04100	SUBPROVIDER - IRF	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.081016
51.00	05100	RECOVERY ROOM	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782
53.00	05300	ANESTHESIOLOGY	0.020000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762
54.01	05401	ULTRASOUND	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.083490
65.00	06500	RESPIRATORY THERAPY	0.083392
66.00	06600	PHYSICAL THERAPY	0.213703
67.00	06700	OCCUPATIONAL THERAPY	0.102232
68.00	06800	SPEECH PATHOLOGY	0.216642
69.00	06900	ELECTROCARDIOLOGY	0.092081
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265
74.00	07400	RENAL DIALYSIS	0.247988
76.00	03950	ANCILLARY	0.000000
76.01	03610	SLEEP LAB	0.000000
76.03	03951	WOUND CARE	0.218925
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.095239
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:11 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,581,380		41,581,380	0	41,581,380	30.00
31.00	03100	INTENSIVE CARE UNIT	12,221,221		12,221,221	61	12,221,282	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	4,086,923		4,086,923	0	4,086,923	31.01
41.00	04100	SUBPROVIDER - IRF	3,217,423		3,217,423	0	3,217,423	41.00
43.00	04300	NURSERY	1,738,475		1,738,475	0	1,738,475	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,722,560		28,722,560	0	28,722,560	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,304,794		4,304,794	0	4,304,794	52.00
53.00	05300	ANESTHESIOLOGY	378,981		378,981	0	378,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,673,655		19,673,655	0	19,673,655	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	17,328,245		17,328,245	0	17,328,245	60.00
65.00	06500	RESPIRATORY THERAPY	3,654,234	0	3,654,234	0	3,654,234	65.00
66.00	06600	PHYSICAL THERAPY	4,326,966	0	4,326,966	0	4,326,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,050,003	0	1,050,003	0	1,050,003	67.00
68.00	06800	SPEECH PATHOLOGY	824,823	0	824,823	0	824,823	68.00
69.00	06900	ELECTROCARDIOLOGY	14,273,923		14,273,923	0	14,273,923	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,463,649		2,463,649	0	2,463,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,865,458		33,865,458	0	33,865,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,291,505		32,291,505	0	32,291,505	73.00
74.00	07400	RENAL DIALYSIS	891,466		891,466	0	891,466	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,768,584		2,768,584	0	2,768,584	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	17,707,898		17,707,898	0	17,707,898	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,339,000		3,339,000		3,339,000	92.00
200.00		Subtotal (see instructions)	250,711,166	0	250,711,166	61	250,711,227	200.00
201.00		Less Observation Beds	3,339,000		3,339,000		3,339,000	201.00
202.00		Total (see instructions)	247,372,166	0	247,372,166	61	247,372,227	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:11 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	132,026,301		132,026,301			30.00
31.00	03100	INTENSIVE CARE UNIT	36,767,251		36,767,251			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	20,136,057		20,136,057			31.01
41.00	04100	SUBPROVIDER - IRF	7,596,480		7,596,480			41.00
43.00	04300	NURSERY	3,474,181		3,474,181			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,350,898	184,177,286	354,528,184	0.081016	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,988,631	677,564	15,666,195	0.274782	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,950,374	9,998,508	18,948,882	0.020000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,528,424	185,576,736	232,105,160	0.084762	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	83,204,628	124,343,972	207,548,600	0.083490	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	40,652,301	3,167,530	43,819,831	0.083392	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,054,523	7,193,013	20,247,536	0.213703	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,203,932	1,066,847	10,270,779	0.102232	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,756,000	1,051,305	3,807,305	0.216642	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	54,534,922	100,480,747	155,015,669	0.092081	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,831,189	18,382,870	43,214,059	0.057010	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,372,386	60,000,769	173,373,155	0.195333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,536,559	131,249,479	197,786,038	0.163265	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,514,987	79,815	3,594,802	0.247988	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	278,490	12,367,791	12,646,281	0.218925	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	47,547,856	138,383,082	185,930,938	0.095239	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,726,830	7,451,792	11,178,622	0.298695	0.000000	92.00
200.00		Subtotal (see instructions)	904,033,200	985,649,106	1,889,682,306			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	904,033,200	985,649,106	1,889,682,306			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 11:11 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT			31.01
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
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	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I | Date/Time Prepared: 5/31/2018 11:11 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	4,669,622	0	4,669,622	48,057	97.17	30.00
31.00	INTENSIVE CARE UNIT	814,755		814,755	7,399	110.12	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	303,316		303,316	2,723	111.39	31.01
41.00	SUBPROVIDER - IRF	517,376	0	517,376	2,800	184.78	41.00
43.00	NURSERY	98,053		98,053	1,008	97.27	43.00
200.00	Total (lines 30 through 199)	6,403,122		6,403,122	61,987		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	20,527	1,994,609				30.00
31.00	INTENSIVE CARE UNIT	3,302	363,616				31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0				31.01
41.00	SUBPROVIDER - IRF	1,810	334,452				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	25,639	2,692,677				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,523,866	354,528,184	0.007119	70,253,136	500,132	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	499,491	15,666,195	0.031883	28,918	922	52.00
53.00	05300	ANESTHESIOLOGY	42,633	18,948,882	0.002250	3,031,170	6,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,819,791	232,105,160	0.007840	22,203,610	174,076	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	756,455	207,548,600	0.003645	36,734,353	133,897	60.00
65.00	06500	RESPIRATORY THERAPY	131,533	43,819,831	0.003002	21,985,209	66,000	65.00
66.00	06600	PHYSICAL THERAPY	663,344	20,247,536	0.032762	5,451,461	178,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,249	10,270,779	0.000511	3,656,588	1,869	67.00
68.00	06800	SPEECH PATHOLOGY	3,923	3,807,305	0.001030	1,285,943	1,325	68.00
69.00	06900	ELECTROCARDIOLOGY	1,177,209	155,015,669	0.007594	23,056,629	175,092	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,447	43,214,059	0.000843	11,536,038	9,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	558,642	173,373,155	0.003222	48,571,841	156,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,440	197,786,038	0.002136	27,827,747	59,440	73.00
74.00	07400	RENAL DIALYSIS	27,132	3,594,802	0.007548	2,021,749	15,260	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	382,333	12,646,281	0.030233	185,066	5,595	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,767,688	185,930,938	0.009507	21,443,046	203,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	374,973	11,178,622	0.033544	1,606,345	53,883	92.00
200.00		Total (lines 50 through 199)	11,193,149	1,689,682,036		300,878,849	1,742,994	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
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	48,057	0.00	20,527	30.00
31.00	03100	INTENSIVE CARE UNIT		0	7,399	0.00	3,302	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	2,723	0.00	0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	2,800	0.00	1,810	41.00
43.00	04300	NURSERY		0	1,008	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	61,987		25,639	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 INTENSIVE CARE UNIT	0	31.01
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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	354,528,184	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	15,666,195	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,948,882	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	232,105,160	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	207,548,600	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	43,819,831	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,247,536	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,270,779	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,807,305	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	155,015,669	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	43,214,059	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	173,373,155	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	197,786,038	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,594,802	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	12,646,281	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	185,930,938	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,178,622	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,689,682,036		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	70,253,136	0	56,066,031	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	28,918	0	5,256	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,031,170	0	2,438,318	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	22,203,610	0	55,191,271	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	36,734,353	0	13,563,519	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	21,985,209	0	1,013,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,451,461	0	163,116	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,656,588	0	51,602	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,285,943	0	19,585	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	23,056,629	0	36,746,891	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	11,536,038	0	5,898,931	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	48,571,841	0	25,945,184	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	27,827,747	0	47,784,801	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,021,749	0	65,739	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	185,066	0	3,849,535	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	21,443,046	0	26,763,396	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,606,345	0	2,365,075	0	92.00
200.00		Total (lines 50 through 199)		300,878,849	0	277,931,945	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.081016	56,066,031	0	0	4,542,246	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782	5,256	0	0	1,444	52.00
53.00	05300	ANESTHESIOLOGY	0.020000	2,438,318	0	0	48,766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762	55,191,271	0	0	4,678,123	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.083490	13,563,519	0	0	1,132,418	60.00
65.00	06500	RESPIRATORY THERAPY	0.083392	1,013,695	0	0	84,534	65.00
66.00	06600	PHYSICAL THERAPY	0.213703	163,116	0	0	34,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.102232	51,602	0	0	5,275	67.00
68.00	06800	SPEECH PATHOLOGY	0.216642	19,585	0	0	4,243	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092081	36,746,891	0	0	3,383,690	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010	5,898,931	0	0	336,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333	25,945,184	0	0	5,067,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265	47,784,801	0	250,846	7,801,586	73.00
74.00	07400	RENAL DIALYSIS	0.247988	65,739	0	0	16,302	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.218925	3,849,535	0	0	842,759	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.095239	26,763,396	0	0	2,548,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695	2,365,075	0	0	706,436	92.00
200.00		Subtotal (see instructions)		277,931,945	0	250,846	31,235,848	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		277,931,945	0	250,846	31,235,848	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,954		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		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	40,954		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	40,954		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 11:11 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	2,523,866	354,528,184	0.007119	36,119	257	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	499,491	15,666,195	0.031883	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,633	18,948,882	0.002250	709	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,819,791	232,105,160	0.007840	125,295	982	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	756,455	207,548,600	0.003645	730,469	2,663	60.00
65.00	06500	RESPIRATORY THERAPY	131,533	43,819,831	0.003002	1,022	3	65.00
66.00	06600	PHYSICAL THERAPY	663,344	20,247,536	0.032762	1,468,013	48,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,249	10,270,779	0.000511	1,579,897	807	67.00
68.00	06800	SPEECH PATHOLOGY	3,923	3,807,305	0.001030	457,520	471	68.00
69.00	06900	ELECTROCARDIOLOGY	1,177,209	155,015,669	0.007594	96,587	733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,447	43,214,059	0.000843	32,507	27	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	558,642	173,373,155	0.003222	38,019	122	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,440	197,786,038	0.002136	785,185	1,677	73.00
74.00	07400	RENAL DIALYSIS	27,132	3,594,802	0.007548	112,063	846	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	382,333	12,646,281	0.030233	492	15	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,767,688	185,930,938	0.009507	4,063	39	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	11,178,622	0.000000	4,403	0	92.00
200.00		Total (lines 50 through 199)	10,818,176	1,689,682,036		5,472,363	56,739	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 11:11 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
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	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 11:11 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	0	354,528,184	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	15,666,195	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,948,882	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	232,105,160	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	207,548,600	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	43,819,831	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,247,536	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,270,779	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,807,305	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	155,015,669	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	43,214,059	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	173,373,155	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	197,786,038	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,594,802	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	12,646,281	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	185,930,938	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,178,622	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,689,682,036		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 11:11 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	36,119	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	709	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	125,295	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	730,469	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,022	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,468,013	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,579,897	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	457,520	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	96,587	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	32,507	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	38,019	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	785,185	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	112,063	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	492	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,063	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	4,403	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,472,363	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:11 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.081016	0	0	16,669,604	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782	0	0	188,744	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020000	0	0	995,450	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762	0	0	21,659,854	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.083490	0	0	14,055,991	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.083392	0	0	479,578	0	65.00
66.00	06600	PHYSICAL THERAPY	0.213703	0	0	811,337	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.102232	0	0	167,918	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.216642	0	0	272,146	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092081	0	0	7,353,542	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010	0	0	1,217,231	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333	0	0	2,773,822	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265	0	0	14,323,156	0	73.00
74.00	07400	RENAL DIALYSIS	0.247988	0	0	4,893	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.218925	0	0	1,478,476	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.095239	0	0	35,458,415	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695	0	0	1,090,574	0	92.00
200.00		Subtotal (see instructions)		0	0	119,000,731	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	119,000,731	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 11:11 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,350,505		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	51,863		52.00
53.00	05300	ANESTHESIOLOGY	0	19,909		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,835,933		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,173,535		60.00
65.00	06500	RESPIRATORY THERAPY	0	39,993		65.00
66.00	06600	PHYSICAL THERAPY	0	173,385		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,167		67.00
68.00	06800	SPEECH PATHOLOGY	0	58,958		68.00
69.00	06900	ELECTROCARDIOLOGY	0	677,122		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	69,394		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	541,819		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,338,470		73.00
74.00	07400	RENAL DIALYSIS	0	1,213		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	323,675		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	3,377,024		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	325,749		92.00
200.00		Subtotal (see instructions)	0	12,375,714		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	12,375,714		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	48,057	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	48,057	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)	44,198	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)	20,527	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)	41,581,380	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)	41,581,380	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)	41,581,380	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)	865.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17,760,987	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)	17,760,987	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:11 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	12,221,282	7,399	1,651.75	3,302	5,454,079	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	4,086,923	2,723	1,500.89	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)	34,235,597	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	57,450,663	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)	2,358,225	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,742,994	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,101,219	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	53,349,444	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)	3,859	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	865.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,339,000	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,669,622	41,581,380	0.112301	3,339,000	374,973	90.00
91.00	Nursing School cost	0	41,581,380	0.000000	3,339,000	0	91.00
92.00	Allied health cost	0	41,581,380	0.000000	3,339,000	0	92.00
93.00	All other Medical Education	0	41,581,380	0.000000	3,339,000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/31/2018 11:11 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)	2,800	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,800	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)	2,800	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,810	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)	3,217,423	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)	3,217,423	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,217,423	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,149.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,079,835	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)	2,079,835	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 11:11 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	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	824,951	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,904,786	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)	334,452	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	56,739	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	391,191	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,513,595	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: 15-0035
Component CCN: 15-T035
Period: From 01/01/2017 To 12/31/2017
Worksheet D-1
Date/Time Prepared: 5/31/2018 11:11 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	517,376	3,217,423	0.160804	0	0	90.00
91.00	Nursing School cost	0	3,217,423	0.000000	0	0	91.00
92.00	Allied health cost	0	3,217,423	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,217,423	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:11 am

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		61,120,928		30.00
31.00	03100	INTENSIVE CARE UNIT		17,176,302		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.081016	70,253,136	5,691,628	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782	28,918	7,946	52.00
53.00	05300	ANESTHESIOLOGY	0.020000	3,031,170	60,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762	22,203,610	1,882,022	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.083490	36,734,353	3,066,951	60.00
65.00	06500	RESPIRATORY THERAPY	0.083392	21,985,209	1,833,391	65.00
66.00	06600	PHYSICAL THERAPY	0.213703	5,451,461	1,164,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.102232	3,656,588	373,820	67.00
68.00	06800	SPEECH PATHOLOGY	0.216642	1,285,943	278,589	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092081	23,056,629	2,123,077	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010	11,536,038	657,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333	48,571,841	9,487,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265	27,827,747	4,543,297	73.00
74.00	07400	RENAL DIALYSIS	0.247988	2,021,749	501,369	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.218925	185,066	40,516	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.095239	21,443,046	2,042,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695	1,606,345	479,807	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		300,878,849	34,235,597	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)		300,878,849		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:11 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		4,906,740		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.081016	36,119	2,926	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020000	709	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762	125,295	10,620	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.083490	730,469	60,987	60.00
65.00	06500	RESPIRATORY THERAPY	0.083392	1,022	85	65.00
66.00	06600	PHYSICAL THERAPY	0.213703	1,468,013	313,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.102232	1,579,897	161,516	67.00
68.00	06800	SPEECH PATHOLOGY	0.216642	457,520	99,118	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092081	96,587	8,894	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010	32,507	1,853	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333	38,019	7,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265	785,185	128,193	73.00
74.00	07400	RENAL DIALYSIS	0.247988	112,063	27,790	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.218925	492	108	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.095239	4,063	387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695	4,403	1,315	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,472,363	824,951	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)		5,472,363		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:11 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		15,879,174		30.00
31.00	03100	INTENSIVE CARE UNIT		4,359,418		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		9,581,437		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		930,240		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.081016	12,856,786	1,041,605	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782	4,207,446	1,156,130	52.00
53.00	05300	ANESTHESIOLOGY	0.020000	1,005,217	20,104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762	6,137,206	520,202	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.083490	9,980,827	833,299	60.00
65.00	06500	RESPIRATORY THERAPY	0.083392	1,334,508	111,287	65.00
66.00	06600	PHYSICAL THERAPY	0.213703	790,744	168,984	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.102232	376,340	38,474	67.00
68.00	06800	SPEECH PATHOLOGY	0.216642	145,670	31,558	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092081	4,320,539	397,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010	968,822	55,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333	3,091,290	603,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265	8,504,339	1,388,461	73.00
74.00	07400	RENAL DIALYSIS	0.247988	160,809	39,879	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.218925	29,022	6,354	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.095239	6,318,640	601,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695	470,196	140,445	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		60,698,401	7,155,467	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)		60,698,401		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 11:11 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 INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		562,764		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.081016	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.274782	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084762	1,314	111	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.083490	806,220	67,311	60.00
65.00	06500	RESPIRATORY THERAPY	0.083392	2,435,797	203,126	65.00
66.00	06600	PHYSICAL THERAPY	0.213703	166,702	35,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.102232	166,577	17,029	67.00
68.00	06800	SPEECH PATHOLOGY	0.216642	55,850	12,099	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092081	12,583	1,159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.057010	634,784	36,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195333	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163265	1,192,415	194,680	73.00
74.00	07400	RENAL DIALYSIS	0.247988	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.218925	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.095239	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298695	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,472,242	567,329	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)		5,472,242		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 11:11 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)	31,495,866	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,251,488	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	2,270,720	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	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	227.43	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.88	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.64	31.00
32.00	Sum of lines 30 and 31	21.52	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.97	33.00
34.00	Disproportionate share adjustment (see instructions)	727,448	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 11:11 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	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000257603	0.000292002	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,539,818	1,975,889	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,151,699	498,033	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,649,732		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	46,395,254		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)	46,395,254	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,633,166	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	8,460	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	50,036,880	59.00
60.00	Primary payer payments	21,897	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	50,014,983	61.00
62.00	Deductibles billed to program beneficiaries	4,088,784	62.00
63.00	Coinsurance billed to program beneficiaries	385,987	63.00
64.00	Allowable bad debts (see instructions)	427,352	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	277,779	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	190,657	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	45,817,991	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	125,955	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)		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)	57,555	70.93
70.94	HRR adjustment amount (see instructions)	-60,584	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 11:11 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)		45,689,007	71.00
71.01	Sequestration adjustment (see instructions)		913,780	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		44,203,240	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)		571,987	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,637,971	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	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	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	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
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/31/2018 11:11 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	40,954	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	31,235,848	2.00
3.00	OPPS payments	29,995,515	3.00
4.00	Outlier payment (see instructions)	135,274	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)	40,954	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	250,846	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)	250,846	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	250,846	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	209,892	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)	40,954	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)	30,130,789	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)	5,564,661	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)	24,607,082	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)	24,607,082	30.00
31.00	Primary payer payments	15,042	31.00
32.00	Subtotal (line 30 minus line 31)	24,592,040	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)	581,801	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	378,171	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	397,272	36.00
37.00	Subtotal (see instructions)	24,970,211	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)	24,970,211	40.00
40.01	Sequestration adjustment (see instructions)	499,404	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	24,424,135	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	46,672	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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2018 11:11 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		44,010,067		24,101,393	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		193,173		322,742	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)		44,203,240		24,424,135	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		571,987		46,672	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		44,775,227		24,470,807	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: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2018 11:11 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		2,860,644		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)		2,860,644		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		16,205		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,876,849		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/31/2018 11:11 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 IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/31/2018 11:11 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,891,017	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0056	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	78,925	3.00
4.00	Outlier Payments	21,582	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)	7.671233	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)	2,991,524	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)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,991,524	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,991,524	19.00
20.00	Deductibles	6,580	20.00
21.00	Subtotal (line 19 minus line 20)	2,984,944	21.00
22.00	Coinsurance	49,679	22.00
23.00	Subtotal (line 21 minus line 22)	2,935,265	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	454	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	295	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	454	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,935,560	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)	2,935,560	32.00
32.01	Sequestration adjustment (see instructions)	58,711	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,860,644	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)	16,205	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	6,649	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	21,582	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/31/2018 11:11 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	-2,373,824	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	79,875,413	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,159,938	0	0	0	6.00
7.00	Inventory	7,968,425	0	0	0	7.00
8.00	Prepaid expenses	1,213,903	0	0	0	8.00
9.00	Other current assets	-64,893	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)	66,459,086	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,615,241	0	0	0	12.00
13.00	Land improvements	4,918,669	0	0	0	13.00
14.00	Accumulated depreciation	-2,465,228	0	0	0	14.00
15.00	Buildings	191,907,250	0	0	0	15.00
16.00	Accumulated depreciation	-28,031,045	0	0	0	16.00
17.00	Leasehold improvements	5,493,866	0	0	0	17.00
18.00	Accumulated depreciation	-1,875,266	0	0	0	18.00
19.00	Fixed equipment	6,742,582	0	0	0	19.00
20.00	Accumulated depreciation	-4,133,385	0	0	0	20.00
21.00	Automobiles and trucks	372,137	0	0	0	21.00
22.00	Accumulated depreciation	-356,260	0	0	0	22.00
23.00	Major movable equipment	56,247,596	0	0	0	23.00
24.00	Accumulated depreciation	-42,984,493	0	0	0	24.00
25.00	Minor equipment depreciable	18,634,399	0	0	0	25.00
26.00	Accumulated depreciation	-13,106,358	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)	202,979,705	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,642,297	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,642,297	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	280,081,088	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,041,355	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,490,580	0	0	0	38.00
39.00	Payroll taxes payable	854,896	0	0	0	39.00
40.00	Notes and loans payable (short term)	25,001	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-128,565,206	0	0	0	43.00
44.00	Other current liabilities	2,300,635	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-105,852,739	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,664	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,197,366	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,214,030	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-91,638,709	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	371,719,797				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)	371,719,797	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	280,081,088	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/31/2018 11:11 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		332,249,536		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		39,470,261				2.00
3.00	Total (sum of line 1 and line 2)		371,719,797		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)		371,719,797		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		371,719,797		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	PRIOR PERIOD ADJUSTMENT		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: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2018 11:11 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	135,500,482		135,500,482	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,596,480		7,596,480	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)	143,096,962		143,096,962	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	36,767,251		36,767,251	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	20,136,057		20,136,057	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)	56,903,308		56,903,308	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	200,000,270		200,000,270	17.00
18.00	Ancillary services	652,758,244	839,814,232	1,492,572,476	18.00
19.00	Outpatient services	51,274,686	145,834,874	197,109,560	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	904,033,200	985,649,106	1,889,682,306	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		281,157,077		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)		281,157,077		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0035	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/31/2018 11:11 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,889,682,306	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,569,836,736	2.00
3.00	Net patient revenues (line 1 minus line 2)	319,845,570	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	281,157,077	4.00
5.00	Net income from service to patients (line 3 minus line 4)	38,688,493	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	781,768	24.00
25.00	Total other income (sum of lines 6-24)	781,768	25.00
26.00	Total (line 5 plus line 25)	39,470,261	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	39,470,261	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0035 | Period: From 01/01/2017 To 12/31/2017 | Worksheet L Parts I-III Date/Time Prepared: 5/31/2018 11:11 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,372,537	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	110,214	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)	150.36	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.88	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	18.64	8.00
9.00	Sum of lines 7 and 8	21.52	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.46	10.00
11.00	Disproportionate share adjustment (see instructions)	150,415	11.00
12.00	Total prospective capital payments (see instructions)	3,633,166	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