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: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/23/2018 5:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/23/2018 Time: 5:03 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) 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	330,005	-426,997	0	182,992	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	41,053	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	371,058	-426,997	0	182,992	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: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 4:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RUSH SWING BEDS	15Z304	99915		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		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.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						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: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 4:25 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital 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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	91,951	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:		Contractor's Number:	141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:		Zip Code:	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	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: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2018 4:25 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/10/2018	Y	04/10/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 4:25 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON		HACKETT		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-633-4705		LHACKETT@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 4:25 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2018 4:25 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	35,448.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	35,448.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	35,448.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,037	107	1,477			1.00
2.00	HMO and other (see instructions)	31	5				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	203	0	203			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,240	107	1,694			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,240	107	1,694	0.00	264.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	264.66	27.00
28.00	Observation Bed Days		0	771			28.00
29.00	Ambulance Trips	598					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	335	36	494	1.00
2.00	HMO and other (see instructions)			9	3		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	335	36	494	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/23/2018 4:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.364467	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,574,096	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	8,935,561	6.00
7.00	Medicaid cost (line 1 times line 6)	3,256,717	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)	682,621	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	506,024	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	682,621	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)	178,004	0	178,004	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	64,877	0	64,877	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	64,877	0	64,877	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,307,961	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	378,436	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	582,210	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,725,751	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,197,220	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,262,097	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,944,718	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,189,642	2,189,642	0	2,189,642	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	388,721	3,254,615	3,643,336	6,369	3,649,705	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,132,071	2,443,245	4,575,316	18,656	4,593,972	5.00
7.00	00700	OPERATION OF PLANT	283,072	621,686	904,758	25,962	930,720	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	59,288	59,288	8.00
9.00	00900	HOUSEKEEPING	280,670	152,648	433,318	-34,414	398,904	9.00
10.00	01000	DIETARY	332,613	254,223	586,836	-402,058	184,778	10.00
11.00	01100	CAFETERIA	0	0	0	426,932	426,932	11.00
13.00	01300	NURSING ADMINISTRATION	197,892	3,208	201,100	-124,370	76,730	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	53,243	75,534	128,777	-1,729	127,048	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,130	69,975	417,105	-721	416,384	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,674,471	88,216	1,762,687	-804,668	958,019	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	589,390	557,067	1,146,457	-273,411	873,046	50.00
51.00	05100	RECOVERY ROOM	0	4,555	4,555	31,321	35,876	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	980,963	840,408	1,821,371	-7,327	1,814,044	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	624,149	811,747	1,435,896	0	1,435,896	60.00
65.00	06500	RESPIRATORY THERAPY	102,992	7,555	110,547	-88	110,459	65.00
66.00	06600	PHYSICAL THERAPY	232,207	104,930	337,137	29,327	366,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,461	558	151,019	29,559	180,578	67.00
68.00	06800	SPEECH PATHOLOGY	88,671	239	88,910	-59,158	29,752	68.00
69.00	06900	ELECTROCARDIOLOGY	148,523	3,354	151,877	-430	151,447	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,734	13,734	319,428	333,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	54,410	54,410	0	54,410	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	523,485	4,372,852	4,896,337	-3,249	4,893,088	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,197,553	142,741	2,340,294	808,894	3,149,188	90.00
90.01	09001	SURGICAL ASSOCIATES	77,327	529,395	606,722	-1,413	605,309	90.01
90.02	09002	ORTHOPAEDICS	43,755	301,237	344,992	-187	344,805	90.02
90.03	09003	RHEUMATOLOGY	512,081	9,271	521,352	-666	520,686	90.03
90.04	09004	ENDOCRINOLOGY	114,150	7,454	121,604	0	121,604	90.04
90.05	09005	PEDIATRICS	297,731	14,715	312,446	-104	312,342	90.05
90.06	09006	WOMEN'S HEALTH	299,095	10,471	309,566	-2,991	306,575	90.06
90.07	09007	PAIN MANAGEMENT	84,908	5,381	90,289	-132	90,157	90.07
91.00	09100	EMERGENCY	853,963	1,132,014	1,985,977	-32,969	1,953,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	598,270	74,897	673,167	-5,651	667,516	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,209,557	18,151,977	32,361,534	0	32,361,534	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	63,614	30	63,644	0	63,644	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	14,273,171	18,152,007	32,425,178	0	32,425,178	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-544,123	1,645,519		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-15,067	3,634,638		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,013,018	3,580,954		5.00
7.00	00700	OPERATION OF PLANT	0	930,720		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,288		8.00
9.00	00900	HOUSEKEEPING	-218	398,686		9.00
10.00	01000	DIETARY	-839	183,939		10.00
11.00	01100	CAFETERIA	-234,797	192,135		11.00
13.00	01300	NURSING ADMINISTRATION	-390	76,340		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-983	126,065		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,956	409,428		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,241	956,778		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-424,915	448,131		50.00
51.00	05100	RECOVERY ROOM	0	35,876		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-453,430	1,360,614		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	-459	1,435,437		60.00
65.00	06500	RESPIRATORY THERAPY	0	110,459		65.00
66.00	06600	PHYSICAL THERAPY	-614	365,850		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	180,578		67.00
68.00	06800	SPEECH PATHOLOGY	0	29,752		68.00
69.00	06900	ELECTROCARDIOLOGY	-4	151,443		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-261	332,901		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	54,410		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-83,365	4,809,723		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-2,336,965	812,223		90.00
90.01	09001	SURGICAL ASSOCIATES	-492,282	113,027		90.01
90.02	09002	ORTHOPAEDICS	-284,819	59,986		90.02
90.03	09003	RHEUMATOLOGY	-501,404	19,282		90.03
90.04	09004	ENDOCRINOLOGY	-127,394	-5,790		90.04
90.05	09005	PEDIATRICS	-254,848	57,494		90.05
90.06	09006	WOMEN'S HEALTH	-283,798	22,777		90.06
90.07	09007	PAIN MANAGEMENT	-70,495	19,662		90.07
91.00	09100	EMERGENCY	0	1,953,008		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	667,516		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,132,685	25,228,849		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	0	63,644		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,132,685	25,292,493		200.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/23/2018 4:25 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY AND LINEN				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	59,288	1.00
	0		0	59,288	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	241,981	184,951	1.00
	0		241,981	184,951	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	319,428	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	0		0	319,428	
	D - AMBULANCE RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	188	0	1.00
2.00	OPERATION OF PLANT	7.00	1,094	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	487	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	58	0	4.00
5.00	EMERGENCY	91.00	1,047	0	5.00
	0		2,874	0	
	E - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6,218	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	18,656	0	2.00
3.00	OPERATION OF PLANT	7.00	24,874	0	3.00
4.00	HOUSEKEEPING	9.00	24,874	0	4.00
5.00	DIETARY	10.00	24,874	0	5.00
6.00	RECOVERY ROOM	51.00	34,672	0	6.00
7.00	PHYSICAL THERAPY	66.00	29,566	0	7.00
8.00	OCCUPATIONAL THERAPY	67.00	29,566	0	8.00
9.00	CLINIC	90.00	24,874	0	9.00
	0		218,174	0	
	F - PHYSICIAN RECLASS				
1.00	CLINIC	90.00	785,614	0	1.00
	0		785,614	0	
500.00	Grand Total: Increases		1,248,643	563,667	500.00

RECLASSIFICATIONS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/23/2018 4:25 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	59,288	0		1.00
	0		0	59,288			
	B - DIETARY/ CAFETERIA						
1.00	DIETARY	10.00	241,981	184,951	0		1.00
	0		241,981	184,951			
	C - MED SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37	0		1.00
2.00	OPERATION OF PLANT	7.00	0	6	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,729	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	721	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	19,541	0		5.00
6.00	RECOVERY ROOM	51.00	0	3,351	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,385	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	88	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	239	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	7	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	27	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	430	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,249	0		13.00
14.00	CLINIC	90.00	0	1,594	0		14.00
15.00	SURGICAL ASSOCIATES	90.01	0	1,413	0		15.00
16.00	ORTHOPAEDICS	90.02	0	187	0		16.00
17.00	RHEUMATOLOGY	90.03	0	666	0		17.00
18.00	PEDIATRICS	90.05	0	104	0		18.00
19.00	WOMEN'S HEALTH	90.06	0	2,991	0		19.00
20.00	PAIN MANAGEMENT	90.07	0	132	0		20.00
21.00	EMERGENCY	91.00	0	34,016	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	2,777	0		22.00
23.00	OPERATING ROOM	50.00	0	238,738	0		23.00
	0		0	319,428			
	D - AMBULANCE RECLASS						
1.00	AMBULANCE SERVICES	95.00	2,874	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		2,874	0			
	E - SALARY RECLASS						
1.00	NURSING ADMINISTRATION	13.00	124,370	0	0		1.00
2.00	OPERATING ROOM	50.00	34,673	0	0		2.00
3.00	SPEECH PATHOLOGY	68.00	59,131	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		218,174	0			
	F - PHYSICIAN RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	785,614	0	0		1.00
	0		785,614	0			
500.00	Grand Total: Decreases		1,248,643	563,667			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

		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	188,708	0	0	0	0	1.00
2.00	Land Improvements	421,224	19,914	0	19,914	14,830	2.00
3.00	Buildings and Fixtures	16,186,031	8,525	0	8,525	629,140	3.00
4.00	Building Improvements	209,065	4,436,439	0	4,436,439	-2,929,226	4.00
5.00	Fixed Equipment	1,190,451	31,035	0	31,035	11,392	5.00
6.00	Movable Equipment	14,450,420	763,513	0	763,513	4,260,935	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,645,899	5,259,426	0	5,259,426	1,987,071	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,645,899	5,259,426	0	5,259,426	1,987,071	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	188,708	0	1.00
2.00	Land Improvements	426,308	0	2.00
3.00	Buildings and Fixtures	15,565,416	0	3.00
4.00	Building Improvements	7,574,730	0	4.00
5.00	Fixed Equipment	1,210,094	0	5.00
6.00	Movable Equipment	10,952,998	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,918,254	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,918,254	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2018 4:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,712,923	0	206,622	270,097	0	1.00
3.00	Total (sum of lines 1-2)	1,712,923	0	206,622	270,097	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,189,642		1.00
3.00	Total (sum of lines 1-2)	0	2,189,642		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2018 4:25 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	35,918,254	0	35,918,254	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	35,918,254	0	35,918,254	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,280,132	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,280,132	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	95,290	270,097	0	0	1,645,519	1.00
3.00	Total (sum of lines 1-2)	95,290	270,097	0	0	1,645,519	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/23/2018 4:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,163,176			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	A	-431,670	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/23/2018 4:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	CAFETERIA	B	-98,303	CAFETERIA	11.00	0	33.00
33.01	JAIL MEALS	B	-135,625	CAFETERIA	11.00	0	33.01
33.02	VENDING MACHINES	B	-1,933	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00	SALE OF DRUGS	B	-9,026	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00	SALE OF SUPPLIES	B	-261	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35.00
37.00	PHYSICIAN APPLICATION FEES	B	-3,300	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	NSF FEES	B	-307	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.01
38.00	MEDICAL RECORDS TRANSCRIPTION FEES	B	-6,956	MEDICAL RECORDS & LIBRARY	16.00	0	38.00
41.00	COPIER FEES	B	-18,578	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ATHLETIC TRAINER - SCHOOL REV	B	-9,587	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.01	WELLNESS PROGRAM	B	322	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.01
45.00	OCCUPATIONAL HEALTH	B	-37,903	CLINIC	90.00	0	45.00
45.01	MISC. INCOME	B	-15,082	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	MISC. INCOME	B	-555	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	MISC. INCOME	B	-400	DIETARY	10.00	0	45.03
45.04	MISC. INCOME	B	-614	PHYSICAL THERAPY	66.00	0	45.04
45.05	MISC. INCOME	B	-5,007	DRUGS CHARGED TO PATIENTS	73.00	0	45.05
45.06	MISC. INCOME	B	-20,748	RHEUMATOLOGY	90.03	0	45.06
45.07	MISC. INCOME	B	0	AMBULANCE SERVICES	95.00	0	45.07
45.08	INTEREST INCOME	B	-111,332	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.08
45.09	TELEPHONE SALARY	B	-4,844	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	TELEPHONE OTHER	A	-1,094	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	TELEPHONE BENEFITS	A	-769	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	ADVERTISING	A	-162,908	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	IHA & AHA LOBBYING	A	-3,347	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14	REBATES	A	-1,121	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.14
45.15	REBATES	B	-9,135	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	REBATES	B	-218	HOUSEKEEPING	9.00	0	45.16
45.17	REBATES	B	-439	DIETARY	10.00	0	45.17
45.18	REBATES	B	-869	CAFETERIA	11.00	0	45.18
45.19	REBATES	B	-390	NURSING ADMINISTRATION	13.00	0	45.19
45.20	REBATES	B	-983	CENTRAL SERVICES & SUPPLY	14.00	0	45.20
45.25	REBATES	B	-1,241	ADULTS & PEDIATRICS	30.00	0	45.25
45.26	REBATES	B	-6,187	OPERATING ROOM	50.00	0	45.26
46.00	REBATES	B	-2,252	RADIOLOGY-DIAGNOSTIC	54.00	0	46.00
46.01	REBATES	B	-459	LABORATORY	60.00	0	46.01
46.02	REBATES	B	-4	ELECTROCARDIOLOGY	69.00	0	46.02
46.03	REBATES	B	-69,332	DRUGS CHARGED TO PATIENTS	73.00	0	46.03
46.04	REBATES	B	-84	RHEUMATOLOGY	90.03	0	46.04
46.05	HAF EXPENSE	B	-796,563	ADMINISTRATIVE & GENERAL	5.00	0	46.05
46.07	SAFE SITTER CLASS FEES	A	-405	ADMINISTRATIVE & GENERAL	5.00	0	46.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,132,685				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2018 4:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	429,050	418,728	10,322	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	483,300	451,178	32,122	0	0	2.00
3.00	60.00	LABORATORY	36,000	0	36,000	0	0	3.00
4.00	90.00	CLINIC	2,440,506	2,299,062	141,444	0	0	4.00
5.00	90.01	SURGICAL ASSOCIATES	524,000	492,282	31,718	0	0	5.00
6.00	90.02	ORTHOPAEDICS	299,029	284,819	14,210	0	0	6.00
7.00	90.03	RHEUMATOLOGY	499,653	480,572	19,081	0	0	7.00
8.00	90.04	ENDOCRINOLOGY	129,086	127,394	1,692	0	0	8.00
9.00	90.05	PEDIATRICS	264,224	254,848	9,376	0	0	9.00
10.00	90.06	WOMEN'S HEALTH	298,603	283,798	14,805	0	0	10.00
11.00	90.07	PAIN MANAGEMENT	70,495	70,495	0	0	0	11.00
12.00	91.00	EMERGENCY	1,035,308	0	1,035,308	0	0	12.00
200.00			6,509,254	5,163,176	1,346,078		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	5.00
6.00	90.02	ORTHOPAEDICS	0	0	0	0	0	6.00
7.00	90.03	RHEUMATOLOGY	0	0	0	0	0	7.00
8.00	90.04	ENDOCRINOLOGY	0	0	0	0	0	8.00
9.00	90.05	PEDIATRICS	0	0	0	0	0	9.00
10.00	90.06	WOMEN'S HEALTH	0	0	0	0	0	10.00
11.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	418,728		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	451,178		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	90.00	CLINIC	0	0	0	2,299,062		4.00
5.00	90.01	SURGICAL ASSOCIATES	0	0	0	492,282		5.00
6.00	90.02	ORTHOPAEDICS	0	0	0	284,819		6.00
7.00	90.03	RHEUMATOLOGY	0	0	0	480,572		7.00
8.00	90.04	ENDOCRINOLOGY	0	0	0	127,394		8.00
9.00	90.05	PEDIATRICS	0	0	0	254,848		9.00
10.00	90.06	WOMEN'S HEALTH	0	0	0	283,798		10.00
11.00	90.07	PAIN MANAGEMENT	0	0	0	70,495		11.00
12.00	91.00	EMERGENCY	0	0	0	0		12.00
200.00			0	0	0	5,163,176		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2018 4:25 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					2	1.00
2.00	Line 1 multiplied by 15 hours per week					30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					5	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	39.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.52	40.52	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					3,201	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					3,201	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					3,201	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					3,201	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					203	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					203	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					203	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					203	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2018 4:25 pm

Physical Therapy — Cost

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

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	3,201		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	203		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	3,404		63.00
64.00	Total cost of outside supplier services (from your records)	1,975		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	203		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	203		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2018 4:25 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					15	1.00
2.00	Line 1 multiplied by 15 hours per week					225	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					37	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	292.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.84	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.92	36.92	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	70	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					21,561	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					21,561	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					21,561	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					21,561	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					1,366	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,366	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,366	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,366	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2018 4:25 pm

		Speech Pathology	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.84	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	21,561	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	1,366	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	22,927	63.00
64.00	Total cost of outside supplier services (from your records)	14,016	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,366	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,366	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,645,519	1,645,519				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,634,638	12,760	3,647,398			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,580,954	242,645	565,250	4,388,849	4,388,849	5.00
7.00	00700	OPERATION OF PLANT	930,720	128,421	81,221	1,140,362	239,426	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,288	12,626	0	71,914	15,099	8.00
9.00	00900	HOUSEKEEPING	398,686	27,665	80,302	506,653	106,375	9.00
10.00	01000	DIETARY	183,939	53,319	30,357	267,615	56,187	10.00
11.00	01100	CAFETERIA	192,135	17,722	63,597	273,454	57,413	11.00
13.00	01300	NURSING ADMINISTRATION	76,340	11,783	19,323	107,446	22,559	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	126,065	37,877	13,993	177,935	37,359	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	409,428	25,060	91,232	525,720	110,378	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	956,778	126,581	233,736	1,317,095	276,532	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	448,131	103,993	145,790	697,914	146,531	50.00
51.00	05100	RECOVERY ROOM	35,876	12,032	9,112	57,020	11,972	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,360,614	141,353	257,830	1,759,797	369,480	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,435,437	39,869	164,038	1,639,344	344,190	60.00
65.00	06500	RESPIRATORY THERAPY	110,459	2,510	27,068	140,037	29,402	65.00
66.00	06600	PHYSICAL THERAPY	365,850	71,596	68,799	506,245	106,289	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,578	16,534	47,314	244,426	51,319	67.00
68.00	06800	SPEECH PATHOLOGY	29,752	3,468	7,764	40,984	8,605	68.00
69.00	06900	ELECTROCARDIOLOGY	151,443	7,702	39,035	198,180	41,609	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	332,901	0	0	332,901	69,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	54,410	0	0	54,410	11,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,809,723	6,820	137,581	4,954,124	1,040,151	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	812,223	248,388	790,564	1,851,175	388,665	90.00
90.01	09001	SURGICAL ASSOCIATES	113,027	30,079	20,323	163,429	34,313	90.01
90.02	09002	ORTHOPAEDICS	59,986	20,653	11,500	92,139	19,345	90.02
90.03	09003	RHEUMATOLOGY	19,282	27,569	134,584	181,435	38,093	90.03
90.04	09004	ENDOCRINOLOGY	-5,790	6,897	30,001	31,108	6,531	90.04
90.05	09005	PEDIATRICS	57,494	27,378	78,249	163,121	34,248	90.05
90.06	09006	WOMEN'S HEALTH	22,777	20,596	78,608	121,981	25,611	90.06
90.07	09007	PAIN MANAGEMENT	19,662	0	22,315	41,977	8,813	90.07
91.00	09100	EMERGENCY	1,953,008	73,914	224,712	2,251,634	472,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	667,516	71,424	156,481	895,421	187,999	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,228,849	1,629,234	3,630,679	25,195,845	4,368,557	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	63,644	16,285	16,719	96,648	20,292	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,292,493	1,645,519	3,647,398	25,292,493	4,388,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,379,788					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,807	100,820				8.00
9.00	00900	HOUSEKEEPING	30,255	7,076	650,359			9.00
10.00	01000	DIETARY	58,309	2,901	28,390	413,402		10.00
11.00	01100	CAFETERIA	19,381	0	9,436	0	359,684	11.00
13.00	01300	NURSING ADMINISTRATION	12,885	0	6,274	0	1,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,422	0	20,168	0	3,891	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,405	0	13,343	0	20,231	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	138,429	65,740	67,401	413,402	37,155	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,727	6,599	55,373	0	18,286	50.00
51.00	05100	RECOVERY ROOM	13,158	0	6,406	0	1,751	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,583	4,263	75,266	0	33,654	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	43,601	0	21,229	0	27,818	60.00
65.00	06500	RESPIRATORY THERAPY	2,745	849	1,336	0	3,891	65.00
66.00	06600	PHYSICAL THERAPY	78,297	1,985	38,123	0	9,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,081	913	8,804	0	4,280	67.00
68.00	06800	SPEECH PATHOLOGY	3,792	39	1,846	0	584	68.00
69.00	06900	ELECTROCARDIOLOGY	8,423	0	4,101	0	4,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,459	0	3,632	0	13,617	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	271,643	0	132,262	0	85,202	90.00
90.01	09001	SURGICAL ASSOCIATES	32,894	0	16,016	0	3,307	90.01
90.02	09002	ORTHOPAEDICS	22,586	0	10,997	0	1,945	90.02
90.03	09003	RHEUMATOLOGY	30,150	0	14,680	0	9,726	90.03
90.04	09004	ENDOCRINOLOGY	7,543	0	3,673	0	389	90.04
90.05	09005	PEDIATRICS	29,940	0	14,578	0	7,976	90.05
90.06	09006	WOMEN'S HEALTH	22,523	0	10,966	0	3,891	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	3,112	90.07
91.00	09100	EMERGENCY	80,832	10,455	39,357	0	28,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	78,109	0	38,031	0	34,821	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,361,979	100,820	641,688	413,402	359,684	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	17,809	0	8,671	0	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,379,788	100,820	650,359	413,402	359,684	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	151,109					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	280,775				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,250	698,327			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,761	10,503	300,044	2,652,062	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,663	11,478	65,986	1,128,557	0	50.00
51.00	05100	RECOVERY ROOM	1,228	287	0	91,822	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,270	9,945	79,893	2,510,151	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	19,214	119,337	0	2,214,733	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,774	1,055	1,480	183,569	0	65.00
66.00	06600	PHYSICAL THERAPY	6,827	1,386	0	748,878	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,915	68	0	330,806	0	67.00
68.00	06800	SPEECH PATHOLOGY	313	13	0	56,176	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,111	516	0	260,414	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,232	0	422,028	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	69,871	0	135,705	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,473	4,354	0	6,032,810	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,445	0	2,740,392	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	832	0	250,791	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	147,012	0	90.02
90.03	09003	RHEUMATOLOGY	0	720	0	274,804	0	90.03
90.04	09004	ENDOCRINOLOGY	0	65	0	49,309	0	90.04
90.05	09005	PEDIATRICS	0	1,442	0	251,305	0	90.05
90.06	09006	WOMEN'S HEALTH	0	830	0	185,802	0	90.06
90.07	09007	PAIN MANAGEMENT	0	880	0	54,782	0	90.07
91.00	09100	EMERGENCY	19,414	10,728	250,924	3,164,100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	24,146	4,538	0	1,263,065	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	151,109	280,775	698,327	25,149,073	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	143,420	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	151,109	280,775	698,327	25,292,493	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,652,062		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,128,557		50.00
51.00	05100	RECOVERY ROOM	91,822		51.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,151		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
60.00	06000	LABORATORY	2,214,733		60.00
65.00	06500	RESPIRATORY THERAPY	183,569		65.00
66.00	06600	PHYSICAL THERAPY	748,878		66.00
67.00	06700	OCCUPATIONAL THERAPY	330,806		67.00
68.00	06800	SPEECH PATHOLOGY	56,176		68.00
69.00	06900	ELECTROCARDIOLOGY	260,414		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,028		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,705		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,032,810		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,740,392		90.00
90.01	09001	SURGICAL ASSOCIATES	250,791		90.01
90.02	09002	ORTHOPAEDICS	147,012		90.02
90.03	09003	RHEUMATOLOGY	274,804		90.03
90.04	09004	ENDOCRINOLOGY	49,309		90.04
90.05	09005	PEDIATRICS	251,305		90.05
90.06	09006	WOMEN'S HEALTH	185,802		90.06
90.07	09007	PAIN MANAGEMENT	54,782		90.07
91.00	09100	EMERGENCY	3,164,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1,263,065		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,149,073		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	FOUNDATION	143,420		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0		193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	25,292,493		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,760	12,760	12,760		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	242,645	242,645	1,977	244,622	5.00
7.00	00700	OPERATION OF PLANT	0	128,421	128,421	284	13,345	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,626	12,626	0	842	8.00
9.00	00900	HOUSEKEEPING	0	27,665	27,665	281	5,929	9.00
10.00	01000	DIETARY	0	53,319	53,319	106	3,132	10.00
11.00	01100	CAFETERIA	0	17,722	17,722	222	3,200	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,783	11,783	68	1,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,877	37,877	49	2,082	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,060	25,060	319	6,152	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	126,581	126,581	817	15,413	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	103,993	103,993	510	8,167	50.00
51.00	05100	RECOVERY ROOM	0	12,032	12,032	32	667	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	141,353	141,353	902	20,593	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	39,869	39,869	574	19,184	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,510	2,510	95	1,639	65.00
66.00	06600	PHYSICAL THERAPY	0	71,596	71,596	241	5,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,534	16,534	165	2,860	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,468	3,468	27	480	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,702	7,702	136	2,319	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,820	6,820	481	57,980	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	248,388	248,388	2,769	21,662	90.00
90.01	09001	SURGICAL ASSOCIATES	0	30,079	30,079	71	1,912	90.01
90.02	09002	ORTHOPAEDICS	0	20,653	20,653	40	1,078	90.02
90.03	09003	RHEUMATOLOGY	0	27,569	27,569	471	2,123	90.03
90.04	09004	ENDOCRINOLOGY	0	6,897	6,897	105	364	90.04
90.05	09005	PEDIATRICS	0	27,378	27,378	274	1,909	90.05
90.06	09006	WOMEN'S HEALTH	0	20,596	20,596	275	1,427	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	78	491	90.07
91.00	09100	EMERGENCY	0	73,914	73,914	786	26,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	71,424	71,424	547	10,478	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,629,234	1,629,234	12,702	243,491	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	16,285	16,285	58	1,131	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,645,519	1,645,519	12,760	244,622	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	142,050					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,421	14,889				8.00
9.00	00900	HOUSEKEEPING	3,115	1,045	38,035			9.00
10.00	01000	DIETARY	6,003	428	1,660	64,648		10.00
11.00	01100	CAFETERIA	1,995	0	552	0	23,691	11.00
13.00	01300	NURSING ADMINISTRATION	1,327	0	367	0	128	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,264	0	1,179	0	256	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,821	0	780	0	1,333	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,251	9,709	3,942	64,648	2,447	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,708	974	3,238	0	1,204	50.00
51.00	05100	RECOVERY ROOM	1,355	0	375	0	115	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,914	630	4,402	0	2,217	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	4,489	0	1,242	0	1,832	60.00
65.00	06500	RESPIRATORY THERAPY	283	125	78	0	256	65.00
66.00	06600	PHYSICAL THERAPY	8,061	293	2,230	0	641	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,862	135	515	0	282	67.00
68.00	06800	SPEECH PATHOLOGY	390	6	108	0	38	68.00
69.00	06900	ELECTROCARDIOLOGY	867	0	240	0	295	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	212	0	897	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,966	0	7,734	0	5,612	90.00
90.01	09001	SURGICAL ASSOCIATES	3,387	0	937	0	218	90.01
90.02	09002	ORTHOPAEDICS	2,325	0	643	0	128	90.02
90.03	09003	RHEUMATOLOGY	3,104	0	859	0	641	90.03
90.04	09004	ENDOCRINOLOGY	777	0	215	0	26	90.04
90.05	09005	PEDIATRICS	3,082	0	853	0	525	90.05
90.06	09006	WOMEN'S HEALTH	2,319	0	641	0	256	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	205	90.07
91.00	09100	EMERGENCY	8,322	1,544	2,302	0	1,845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	8,041	0	2,224	0	2,294	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,217	14,889	37,528	64,648	23,691	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	1,833	0	507	0	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	142,050	14,889	38,035	64,648	23,691	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	14,930					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,707				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	204	36,669			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,546	1,710	15,755	257,819	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,251	1,868	3,465	136,378	0	50.00
51.00	05100	RECOVERY ROOM	121	47	0	14,744	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,299	1,619	4,195	194,124	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,898	19,426	0	88,514	0	60.00
65.00	06500	RESPIRATORY THERAPY	274	172	78	5,510	0	65.00
66.00	06600	PHYSICAL THERAPY	675	226	0	89,887	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	288	11	0	22,652	0	67.00
68.00	06800	SPEECH PATHOLOGY	31	2	0	4,550	0	68.00
69.00	06900	ELECTROCARDIOLOGY	307	84	0	11,950	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,131	0	7,027	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,374	0	12,011	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	936	709	0	68,803	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,863	0	315,994	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	135	0	36,739	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	24,867	0	90.02
90.03	09003	RHEUMATOLOGY	0	117	0	34,884	0	90.03
90.04	09004	ENDOCRINOLOGY	0	11	0	8,395	0	90.04
90.05	09005	PEDIATRICS	0	235	0	34,256	0	90.05
90.06	09006	WOMEN'S HEALTH	0	135	0	25,649	0	90.06
90.07	09007	PAIN MANAGEMENT	0	143	0	917	0	90.07
91.00	09100	EMERGENCY	1,918	1,746	13,176	131,902	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,386	739	0	98,133	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,930	45,707	36,669	1,625,705	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	19,814	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,930	45,707	36,669	1,645,519	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	257,819		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	136,378		50.00
51.00	05100	RECOVERY ROOM	14,744		51.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,124		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
60.00	06000	LABORATORY	88,514		60.00
65.00	06500	RESPIRATORY THERAPY	5,510		65.00
66.00	06600	PHYSICAL THERAPY	89,887		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,652		67.00
68.00	06800	SPEECH PATHOLOGY	4,550		68.00
69.00	06900	ELECTROCARDIOLOGY	11,950		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,027		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,011		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,803		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	315,994		90.00
90.01	09001	SURGICAL ASSOCIATES	36,739		90.01
90.02	09002	ORTHOPAEDICS	24,867		90.02
90.03	09003	RHEUMATOLOGY	34,884		90.03
90.04	09004	ENDOCRINOLOGY	8,395		90.04
90.05	09005	PEDIATRICS	34,256		90.05
90.06	09006	WOMEN'S HEALTH	25,649		90.06
90.07	09007	PAIN MANAGEMENT	917		90.07
91.00	09100	EMERGENCY	131,902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	98,133		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,625,705		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	FOUNDATION	19,814		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0		193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,645,519		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	85,889					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	666	13,878,044				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,665	2,150,727	-4,388,849	20,903,644		5.00
7.00	00700	OPERATION OF PLANT	6,703	309,040	0	1,140,362	65,855	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	659	0	0	71,914	659	8.00
9.00	00900	HOUSEKEEPING	1,444	305,544	0	506,653	1,444	9.00
10.00	01000	DIETARY	2,783	115,506	0	267,615	2,783	10.00
11.00	01100	CAFETERIA	925	241,981	0	273,454	925	11.00
13.00	01300	NURSING ADMINISTRATION	615	73,522	0	107,446	615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,977	53,243	0	177,935	1,977	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,308	347,130	0	525,720	1,308	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,607	889,344	0	1,317,095	6,607	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,428	554,717	0	697,914	5,428	50.00
51.00	05100	RECOVERY ROOM	628	34,672	0	57,020	628	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,378	981,021	0	1,759,797	7,378	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,081	624,149	0	1,639,344	2,081	60.00
65.00	06500	RESPIRATORY THERAPY	131	102,992	0	140,037	131	65.00
66.00	06600	PHYSICAL THERAPY	3,737	261,773	0	506,245	3,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	180,027	0	244,426	863	67.00
68.00	06800	SPEECH PATHOLOGY	181	29,540	0	40,984	181	68.00
69.00	06900	ELECTROCARDIOLOGY	402	148,523	0	198,180	402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	332,901	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	54,410	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356	523,485	0	4,954,124	356	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,965	3,008,041	0	1,851,175	12,965	90.00
90.01	09001	SURGICAL ASSOCIATES	1,570	77,327	0	163,429	1,570	90.01
90.02	09002	ORTHOPAEDICS	1,078	43,755	0	92,139	1,078	90.02
90.03	09003	RHEUMATOLOGY	1,439	512,081	0	181,435	1,439	90.03
90.04	09004	ENDOCRINOLOGY	360	114,150	0	31,108	360	90.04
90.05	09005	PEDIATRICS	1,429	297,731	0	163,121	1,429	90.05
90.06	09006	WOMEN'S HEALTH	1,075	299,095	0	121,981	1,075	90.06
90.07	09007	PAIN MANAGEMENT	0	84,908	0	41,977	0	90.07
91.00	09100	EMERGENCY	3,858	855,010	0	2,251,634	3,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,728	595,396	0	895,421	3,728	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,039	13,814,430	-4,388,849	20,806,996	65,005	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	850	63,614	0	96,648	850	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,645,519	3,647,398		4,388,849	1,379,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.158670	0.262818		0.209956	20.951909	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		12,760		244,622	142,050	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000919		0.011702	2.157012	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: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	63,752				9.00
10.00	01000	DIETARY	820	2,783	100			10.00
11.00	01100	CAFETERIA	0	925	0	1,849		11.00
13.00	01300	NURSING ADMINISTRATION	0	615	0	10	233,589	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,977	0	20	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,308	0	104	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,580	6,607	100	191	39,820	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	5,428	0	94	19,575	50.00
51.00	05100	RECOVERY ROOM	0	628	0	9	1,899	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	7,378	0	173	35,972	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,081	0	143	29,702	60.00
65.00	06500	RESPIRATORY THERAPY	240	131	0	20	4,288	65.00
66.00	06600	PHYSICAL THERAPY	561	3,737	0	50	10,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	863	0	22	4,506	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	3	484	68.00
69.00	06900	ELECTROCARDIOLOGY	0	402	0	23	4,809	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	356	0	70	14,643	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	12,965	0	438	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,570	0	17	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,078	0	10	0	90.02
90.03	09003	RHEUMATOLOGY	0	1,439	0	50	0	90.03
90.04	09004	ENDOCRINOLOGY	0	360	0	2	0	90.04
90.05	09005	PEDIATRICS	0	1,429	0	41	0	90.05
90.06	09006	WOMEN'S HEALTH	0	1,075	0	20	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	16	0	90.07
91.00	09100	EMERGENCY	2,955	3,858	0	144	30,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,728	0	179	37,326	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	62,902	100	1,849	233,589	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	850	0	0	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	100,820	650,359	413,402	359,684	151,109	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.538165	10.201390	4,134.020000	194.528935	0.646901	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,889	38,035	64,648	23,691	14,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.522513	0.596609	646.480000	12.812872	0.063916	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: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/23/2018 4:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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	1,178,008			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,246	94,400		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	44,065	40,560		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	48,157	8,920		50.00
51.00	05100	RECOVERY ROOM	1,204	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,726	10,800		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	500,676	0		60.00
65.00	06500	RESPIRATORY THERAPY	4,427	200		65.00
66.00	06600	PHYSICAL THERAPY	5,817	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	286	0		67.00
68.00	06800	SPEECH PATHOLOGY	54	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,163	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,689	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	293,149	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,269	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	48,020	0		90.00
90.01	09001	SURGICAL ASSOCIATES	3,492	0		90.01
90.02	09002	ORTHOPAEDICS	0	0		90.02
90.03	09003	RHEUMATOLOGY	3,020	0		90.03
90.04	09004	ENDOCRINOLOGY	273	0		90.04
90.05	09005	PEDIATRICS	6,048	0		90.05
90.06	09006	WOMEN'S HEALTH	3,482	0		90.06
90.07	09007	PAIN MANAGEMENT	3,694	0		90.07
91.00	09100	EMERGENCY	45,009	33,920		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	19,041	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,178,007	94,400		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FOUNDATION	1	0		193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0		193.02
194.00	07950	OTHER NON REIMBURSABLE COST CENTERS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	280,775	698,327		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.238347	7.397532		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,707	36,669		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.038800	0.388443		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,652,062		2,652,062	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,128,557		1,128,557	0	0	50.00
51.00	05100	RECOVERY ROOM	91,822		91,822	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,151		2,510,151	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,214,733		2,214,733	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	183,569	0	183,569	0	0	65.00
66.00	06600	PHYSICAL THERAPY	748,878	0	748,878	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,806	0	330,806	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,176	0	56,176	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	260,414		260,414	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,028		422,028	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,705		135,705	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,032,810		6,032,810	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,740,392		2,740,392	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	250,791		250,791	0	0	90.01
90.02	09002	ORTHOPAEDICS	147,012		147,012	0	0	90.02
90.03	09003	RHEUMATOLOGY	274,804		274,804	0	0	90.03
90.04	09004	ENDOCRINOLOGY	49,309		49,309	0	0	90.04
90.05	09005	PEDIATRICS	251,305		251,305	0	0	90.05
90.06	09006	WOMEN'S HEALTH	185,802		185,802	0	0	90.06
90.07	09007	PAIN MANAGEMENT	54,782		54,782	0	0	90.07
91.00	09100	EMERGENCY	3,164,100		3,164,100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	834,245		834,245		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,263,065		1,263,065	0	0	95.00
200.00		Subtotal (see instructions)	25,983,318	0	25,983,318	0	0	200.00
201.00		Less Observation Beds	834,245		834,245		0	201.00
202.00		Total (see instructions)	25,149,073	0	25,149,073	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,819,384		3,819,384			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,519	2,470,707	2,571,226	0.438918	0.000000	50.00
51.00	05100	RECOVERY ROOM	71,757	651,494	723,251	0.126957	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	792,571	19,302,406	20,094,977	0.124914	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	724,972	9,924,261	10,649,233	0.207971	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	112,760	174,962	287,722	0.638008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	240,916	1,731,450	1,972,366	0.379685	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,422	1,156,036	1,299,458	0.254572	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	80,432	92,068	172,500	0.325658	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	71,275	1,409,952	1,481,227	0.175810	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,464	3,059,631	3,201,095	0.131839	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	56	177,629	177,685	0.763739	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,006,993	11,211,810	12,218,803	0.493732	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,336	1,145,123	1,160,459	2.361472	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	2,295	26,370	28,665	8.749032	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	24,954	24,954	5.891320	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	44,154	44,154	6.223762	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0	1,418	1,418	34.773625	0.000000	90.04
90.05	09005	PEDIATRICS	0	95,196	95,196	2.639869	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	29,256	29,256	6.350902	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	1,822	1,822	30.066959	0.000000	90.07
91.00	09100	EMERGENCY	2,303	6,178,178	6,180,481	0.511950	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,914	1,527,869	1,531,783	0.544623	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,235,151	1,235,151	1.022600	0.000000	95.00
200.00		Subtotal (see instructions)	7,330,369	61,671,897	69,002,266			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,330,369	61,671,897	69,002,266			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000		90.01
90.02	09002	ORTHOPAEDICS	0.000000		90.02
90.03	09003	RHEUMATOLOGY	0.000000		90.03
90.04	09004	ENDOCRINOLOGY	0.000000		90.04
90.05	09005	PEDIATRICS	0.000000		90.05
90.06	09006	WOMEN'S HEALTH	0.000000		90.06
90.07	09007	PAIN MANAGEMENT	0.000000		90.07
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,652,062		2,652,062	0	2,652,062	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,128,557		1,128,557	0	1,128,557	50.00
51.00	05100	RECOVERY ROOM	91,822		91,822	0	91,822	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,510,151		2,510,151	0	2,510,151	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	2,214,733		2,214,733	0	2,214,733	60.00
65.00	06500	RESPIRATORY THERAPY	183,569	0	183,569	0	183,569	65.00
66.00	06600	PHYSICAL THERAPY	748,878	0	748,878	0	748,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,806	0	330,806	0	330,806	67.00
68.00	06800	SPEECH PATHOLOGY	56,176	0	56,176	0	56,176	68.00
69.00	06900	ELECTROCARDIOLOGY	260,414		260,414	0	260,414	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,028		422,028	0	422,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,705		135,705	0	135,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,032,810		6,032,810	0	6,032,810	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,740,392		2,740,392	0	2,740,392	90.00
90.01	09001	SURGICAL ASSOCIATES	250,791		250,791	0	250,791	90.01
90.02	09002	ORTHOPAEDICS	147,012		147,012	0	147,012	90.02
90.03	09003	RHEUMATOLOGY	274,804		274,804	0	274,804	90.03
90.04	09004	ENDOCRINOLOGY	49,309		49,309	0	49,309	90.04
90.05	09005	PEDIATRICS	251,305		251,305	0	251,305	90.05
90.06	09006	WOMEN'S HEALTH	185,802		185,802	0	185,802	90.06
90.07	09007	PAIN MANAGEMENT	54,782		54,782	0	54,782	90.07
91.00	09100	EMERGENCY	3,164,100		3,164,100	0	3,164,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	834,245		834,245		834,245	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,263,065		1,263,065	0	1,263,065	95.00
200.00		Subtotal (see instructions)	25,983,318	0	25,983,318	0	25,983,318	200.00
201.00		Less Observation Beds	834,245		834,245		834,245	201.00
202.00		Total (see instructions)	25,149,073	0	25,149,073	0	25,149,073	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,819,384		3,819,384			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,519	2,470,707	2,571,226	0.438918	0.000000	50.00
51.00	05100	RECOVERY ROOM	71,757	651,494	723,251	0.126957	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	792,571	19,302,406	20,094,977	0.124914	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	724,972	9,924,261	10,649,233	0.207971	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	112,760	174,962	287,722	0.638008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	240,916	1,731,450	1,972,366	0.379685	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,422	1,156,036	1,299,458	0.254572	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	80,432	92,068	172,500	0.325658	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	71,275	1,409,952	1,481,227	0.175810	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,464	3,059,631	3,201,095	0.131839	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	56	177,629	177,685	0.763739	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,006,993	11,211,810	12,218,803	0.493732	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,336	1,145,123	1,160,459	2.361472	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	2,295	26,370	28,665	8.749032	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	24,954	24,954	5.891320	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	44,154	44,154	6.223762	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0	1,418	1,418	34.773625	0.000000	90.04
90.05	09005	PEDIATRICS	0	95,196	95,196	2.639869	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	29,256	29,256	6.350902	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	1,822	1,822	30.066959	0.000000	90.07
91.00	09100	EMERGENCY	2,303	6,178,178	6,180,481	0.511950	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,914	1,527,869	1,531,783	0.544623	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,235,151	1,235,151	1.022600	0.000000	95.00
200.00		Subtotal (see instructions)	7,330,369	61,671,897	69,002,266			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,330,369	61,671,897	69,002,266			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio 11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000		90.01
90.02	09002	ORTHOPAEDICS	0.000000		90.02
90.03	09003	RHEUMATOLOGY	0.000000		90.03
90.04	09004	ENDOCRINOLOGY	0.000000		90.04
90.05	09005	PEDIATRICS	0.000000		90.05
90.06	09006	WOMEN'S HEALTH	0.000000		90.06
90.07	09007	PAIN MANAGEMENT	0.000000		90.07
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	136,378	2,571,226	0.053040	88,039	4,670	50.00
51.00	05100	RECOVERY ROOM	14,744	723,251	0.020386	2,799	57	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,124	20,094,977	0.009660	577,387	5,578	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	88,514	10,649,233	0.008312	503,112	4,182	60.00
65.00	06500	RESPIRATORY THERAPY	5,510	287,722	0.019150	52,178	999	65.00
66.00	06600	PHYSICAL THERAPY	89,887	1,972,366	0.045573	114,780	5,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,652	1,299,458	0.017432	59,517	1,038	67.00
68.00	06800	SPEECH PATHOLOGY	4,550	172,500	0.026377	57,283	1,511	68.00
69.00	06900	ELECTROCARDIOLOGY	11,950	1,481,227	0.008068	54,844	442	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,027	3,201,095	0.002195	54,852	120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,011	177,685	0.067597	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,803	12,218,803	0.005631	598,133	3,368	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	315,994	1,160,459	0.272301	2,826	770	90.00
90.01	09001	SURGICAL ASSOCIATES	36,739	28,665	1.281668	0	0	90.01
90.02	09002	ORTHOPAEDICS	24,867	24,954	0.996514	0	0	90.02
90.03	09003	RHEUMATOLOGY	34,884	44,154	0.790053	0	0	90.03
90.04	09004	ENDOCRINOLOGY	8,395	1,418	5.920310	0	0	90.04
90.05	09005	PEDIATRICS	34,256	95,196	0.359847	0	0	90.05
90.06	09006	WOMEN'S HEALTH	25,649	29,256	0.876709	0	0	90.06
90.07	09007	PAIN MANAGEMENT	917	1,822	0.503293	0	0	90.07
91.00	09100	EMERGENCY	131,902	6,180,481	0.021342	2,303	49	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	81,101	1,531,783	0.052945	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,350,854	63,947,731		2,168,053	28,015	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	ENDOCRINOLOGY	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,571,226	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	723,251	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,094,977	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	10,649,233	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	287,722	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,972,366	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,299,458	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	172,500	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,481,227	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,201,095	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	177,685	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,218,803	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,160,459	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	28,665	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	24,954	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	44,154	0.000000	90.03
90.04	09004	ENDOCRINOLOGY	0	0	0	1,418	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	95,196	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	29,256	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	1,822	0.000000	90.07
91.00	09100	EMERGENCY	0	0	0	6,180,481	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,531,783	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	63,947,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	88,039	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,799	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	577,387	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	503,112	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	52,178	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	114,780	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	59,517	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	57,283	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	54,844	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	54,852	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	598,133	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	2,826	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	ENDOCRINOLOGY	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.000000	2,303	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,168,053	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.438918	0	1,275,806	0	0	50.00
51.00	05100	RECOVERY ROOM	0.126957	0	160,912	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124914	0	6,502,367	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.207971	0	3,759,051	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.638008	0	64,670	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379685	0	750,826	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254572	0	412,607	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.325658	0	24,061	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.175810	0	588,974	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.131839	0	142,923	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.763739	0	60,354	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493732	0	4,874,577	51,895	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.361472	0	316,091	21,090	0	90.00
90.01	09001	SURGICAL ASSOCIATES	8.749032	0	14,594	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.891320	0	6,018	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.223762	0	15,323	0	0	90.03
90.04	09004	ENDOCRINOLOGY	34.773625	0	509	0	0	90.04
90.05	09005	PEDIATRICS	2.639869	0	39	0	0	90.05
90.06	09006	WOMEN'S HEALTH	6.350902	0	2,082	0	0	90.06
90.07	09007	PAIN MANAGEMENT	30.066959	0	68	0	0	90.07
91.00	09100	EMERGENCY	0.511950	0	1,419,525	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544623	0	1,159,509	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.022600		0			95.00
200.00		Subtotal (see instructions)		0	21,550,886	72,985	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	21,550,886	72,985	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	559,974	0		50.00
51.00	05100	RECOVERY ROOM	20,429	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	812,237	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	781,774	0		60.00
65.00	06500	RESPIRATORY THERAPY	41,260	0		65.00
66.00	06600	PHYSICAL THERAPY	285,077	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	105,038	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,836	0		68.00
69.00	06900	ELECTROCARDIOLOGY	103,548	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,843	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	46,095	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,406,735	25,622		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	746,440	49,803		90.00
90.01	09001	SURGICAL ASSOCIATES	127,683	0		90.01
90.02	09002	ORTHOPAEDICS	35,454	0		90.02
90.03	09003	RHEUMATOLOGY	95,367	0		90.03
90.04	09004	ENDOCRINOLOGY	17,700	0		90.04
90.05	09005	PEDIATRICS	103	0		90.05
90.06	09006	WOMEN'S HEALTH	13,223	0		90.06
90.07	09007	PAIN MANAGEMENT	2,045	0		90.07
91.00	09100	EMERGENCY	726,726	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	631,495	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,585,082	75,425		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,585,082	75,425		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.438918	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.126957	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124914	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.207971	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.638008	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379685	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254572	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.325658	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.175810	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.131839	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.763739	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493732	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.361472	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	8.749032	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.891320	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.223762	0	0	0	0	90.03
90.04	09004	ENDOCRINOLOGY	34.773625	0	0	0	0	90.04
90.05	09005	PEDIATRICS	2.639869	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	6.350902	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	30.066959	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.511950	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544623	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.022600		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SURGICAL ASSOCIATES	0	0		90.01
90.02	09002	ORTHOPAEDICS	0	0		90.02
90.03	09003	RHEUMATOLOGY	0	0		90.03
90.04	09004	ENDOCRINOLOGY	0	0		90.04
90.05	09005	PEDIATRICS	0	0		90.05
90.06	09006	WOMEN'S HEALTH	0	0		90.06
90.07	09007	PAIN MANAGEMENT	0	0		90.07
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,465	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,248	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)	1,477	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	203	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	14	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)	1,037	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)	203	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,652,062	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)	219,652	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,432,410	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)	2,432,410	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)	1,082.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,122,065	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,122,065	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	646,474	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,768,539	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	219,652	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)	219,652	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)	771	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,082.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	834,245	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	257,819	2,652,062	0.097215	834,245	81,101	90.00
91.00	Nursing School cost	0	2,652,062	0.000000	834,245	0	91.00
92.00	Allied health cost	0	2,652,062	0.000000	834,245	0	92.00
93.00	All other Medical Education	0	2,652,062	0.000000	834,245	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,465	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,248	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)	1,477	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	203	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	14	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)	107	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,652,062	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)	219,652	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,432,410	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)	2,432,410	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)	1,082.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	115,777	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)	115,777	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	67,215	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	182,992	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	771	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,082.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	834,245	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	257,819	2,652,062	0.097215	834,245	81,101	90.00
91.00	Nursing School cost	0	2,652,062	0.000000	834,245	0	91.00
92.00	Allied health cost	0	2,652,062	0.000000	834,245	0	92.00
93.00	All other Medical Education	0	2,652,062	0.000000	834,245	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,846,490		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.438918	88,039	38,642	50.00
51.00	05100	RECOVERY ROOM	0.126957	2,799	355	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124914	577,387	72,124	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.207971	503,112	104,633	60.00
65.00	06500	RESPIRATORY THERAPY	0.638008	52,178	33,290	65.00
66.00	06600	PHYSICAL THERAPY	0.379685	114,780	43,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254572	59,517	15,151	67.00
68.00	06800	SPEECH PATHOLOGY	0.325658	57,283	18,655	68.00
69.00	06900	ELECTROCARDIOLOGY	0.175810	54,844	9,642	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.131839	54,852	7,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.763739	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493732	598,133	295,317	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.361472	2,826	6,674	90.00
90.01	09001	SURGICAL ASSOCIATES	8.749032	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.891320	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.223762	0	0	90.03
90.04	09004	ENDOCRINOLOGY	34.773625	0	0	90.04
90.05	09005	PEDIATRICS	2.639869	0	0	90.05
90.06	09006	WOMEN'S HEALTH	6.350902	0	0	90.06
90.07	09007	PAIN MANAGEMENT	30.066959	0	0	90.07
91.00	09100	EMERGENCY	0.511950	2,303	1,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544623	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,168,053	646,474	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)		2,168,053		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.438918	0	0	50.00
51.00	05100	RECOVERY ROOM	0.126957	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124914	12,175	1,521	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.207971	26,220	5,453	60.00
65.00	06500	RESPIRATORY THERAPY	0.638008	5,899	3,764	65.00
66.00	06600	PHYSICAL THERAPY	0.379685	73,737	27,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254572	55,504	14,130	67.00
68.00	06800	SPEECH PATHOLOGY	0.325658	8,594	2,799	68.00
69.00	06900	ELECTROCARDIOLOGY	0.175810	1,234	217	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.131839	555	73	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.763739	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493732	49,389	24,385	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.361472	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	8.749032	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.891320	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.223762	0	0	90.03
90.04	09004	ENDOCRINOLOGY	34.773625	0	0	90.04
90.05	09005	PEDIATRICS	2.639869	0	0	90.05
90.06	09006	WOMEN'S HEALTH	6.350902	0	0	90.06
90.07	09007	PAIN MANAGEMENT	30.066959	0	0	90.07
91.00	09100	EMERGENCY	0.511950	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544623	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		233,307	80,339	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		233,307		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		187,799		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.438918	4,289	1,883	50.00
51.00	05100	RECOVERY ROOM	0.126957	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124914	61,111	7,634	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.207971	48,477	10,082	60.00
65.00	06500	RESPIRATORY THERAPY	0.638008	9,738	6,213	65.00
66.00	06600	PHYSICAL THERAPY	0.379685	6,739	2,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.254572	4,492	1,144	67.00
68.00	06800	SPEECH PATHOLOGY	0.325658	2,241	730	68.00
69.00	06900	ELECTROCARDIOLOGY	0.175810	2,004	352	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.131839	2,892	381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.763739	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493732	70,851	34,981	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.361472	532	1,256	90.00
90.01	09001	SURGICAL ASSOCIATES	8.749032	0	0	90.01
90.02	09002	ORTHOPAEDICS	5.891320	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.223762	0	0	90.03
90.04	09004	ENDOCRINOLOGY	34.773625	0	0	90.04
90.05	09005	PEDIATRICS	2.639869	0	0	90.05
90.06	09006	WOMEN'S HEALTH	6.350902	0	0	90.06
90.07	09007	PAIN MANAGEMENT	30.066959	0	0	90.07
91.00	09100	EMERGENCY	0.511950	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544623	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		213,366	67,215	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)		213,366		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/23/2018 4:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,660,507	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,660,507	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,737,112	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	87,387	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,478,722	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)	4,171,003	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)	4,171,003	30.00
31.00	Primary payer payments	1,306	31.00
32.00	Subtotal (line 30 minus line 31)	4,169,697	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)	449,136	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	291,938	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	297,543	36.00
37.00	Subtotal (see instructions)	4,461,635	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)	4,461,635	40.00
40.01	Sequestration adjustment (see instructions)	89,233	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,799,399	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-426,997	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: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,159,423		4,041,999	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	07/12/2017	535,600	3.01
3.02			0	08/15/2017	221,800	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		757,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,159,423		4,799,399	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		330,005		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		426,997	6.02
7.00	Total Medicare program liability (see instructions)		1,489,428		4,372,402	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: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		254,749		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)		254,749		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		41,053		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		295,802		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: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/23/2018 4:25 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/23/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	221,849	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	81,142	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	203	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	302,991	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	302,991	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	302,991	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,152	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	301,839	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	301,839	0	19.00
19.01	Sequestration adjustment (see instructions)	6,037	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	254,749	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	41,053	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/23/2018 4:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,768,539	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,768,539	4.00
5.00	Primary payer payments	979	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,785,245	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,785,245	19.00
20.00	Deductibles (exclude professional component)	349,944	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,435,301	22.00
23.00	Coinsurance	1,974	23.00
24.00	Subtotal (line 22 minus line 23)	1,433,327	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	133,074	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	86,498	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	117,341	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,519,825	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,519,825	30.00
30.01	Sequestration adjustment (see instructions)	30,397	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,159,423	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	330,005	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 5/23/2018 4:25 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	182,992		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	182,992	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	182,992	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	187,799		8.00
9.00	Ancillary service charges	213,366	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	401,165	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	401,165	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	218,173	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	182,992	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	182,992	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	182,992	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	182,992	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	182,992	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	182,992	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	182,992	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/23/2018 4:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,799,112	0	0	0	1.00
2.00	Temporary investments	4,631,264	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,858,355	0	0	0	4.00
5.00	Other receivable	730,040	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,400,398	0	0	0	6.00
7.00	Inventory	945,094	0	0	0	7.00
8.00	Prepaid expenses	446,991	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,010,458	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	35,918,255	0	0	0	15.00
16.00	Accumulated depreciation	-20,622,001	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,296,254	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,306,712	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,913,523	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,059,511	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,544,247	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,517,281	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,366,511	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,366,511	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,883,792	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,422,920				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)	13,422,920	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,306,712	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/23/2018 4:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,399,919		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,023,001				2.00
3.00	Total (sum of line 1 and line 2)		13,422,920		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)		13,422,920		0		11.00
12.00	Deductions (debit adjustments) (specify)	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)		13,422,920		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	Deductions (debit adjustments) (specify)		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: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/23/2018 4:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,819,384		3,819,384	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,819,384		3,819,384	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,819,384		3,819,384	17.00
18.00	Ancillary services	3,431,127	51,418,419	54,849,546	18.00
19.00	Outpatient services	23,848	9,074,340	9,098,188	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,235,151	1,235,151	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	439,969	7,765,603	8,205,572	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,714,328	69,493,513	77,207,841	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,425,178		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)		32,425,178		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/23/2018 4:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,207,841	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,077,743	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,130,098	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,425,178	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,295,080	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 OPERATING EXPENSES/INCOME	1,231,108	24.00
24.01	NON-OPERATING EXPENSES/INCOME	1,086,973	24.01
25.00	Total other income (sum of lines 6-24)	2,318,081	25.00
26.00	Total (line 5 plus line 25)	1,023,001	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,023,001	29.00