

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: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/24/2018 11:54 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/24/2018 Time: 11:54 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

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 KATHERINE SHAW BETHEA (14-0012) 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		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	55,718	62,727	0	0	1.00
2.00 Subprovider - IPF	0	10,520	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	66,238	62,727	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/18/2018 4:09 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: KATHERINE SHAW BETHEA HOSPITAL		PO Box: 403 EAST						1.00			
2.00	City: DIXON		State: IL		Zip Code: 61021		County: LEE		2.00			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		KATHERINE SHAW BETHEA		140012	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		KSB PSYCH		14S012	99914	4	11/01/1983	N	P	O	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		KSB HOME HEALTH		147131	99914		07/07/1976	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2017		12/31/2017		20.00		
21.00	Type of Control (see instructions)					2				21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y		Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.					942	1,575	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	0	25.00

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		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		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.		0			36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		Y		Y	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	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	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	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification 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	

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	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.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
				Respiratory	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	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: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/18/2018 4:09 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:	1,056,792	851,124		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: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/18/2018 4:09 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.						N	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			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
						1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00	
		Beginning		Ending					
		1.00		2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2016	09/30/2017	170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/18/2018 4:09 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	03/22/2018	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			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.			Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			Y			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	02/21/2018	Y	02/21/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/18/2018 4:09 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 relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0012

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

Worksheet S-2
Part II
Date/Time Prepared:
5/18/2018 4:09 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.	DI RECTOR, REIMBURSEMENT	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: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	60	21,900	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		60	21,900	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		66	24,090	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		80				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: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	3,412	1,466	6,634			1.00
2.00 HMO and other (see instructions)	247	0				2.00
3.00 HMO IPF Subprovider	3	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,412	1,466	6,634			7.00
8.00 INTENSIVE CARE UNIT	658	646	1,381			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		405	592			13.00
14.00 Total (see instructions)	4,070	2,517	8,607	3.63	741.21	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	739	1,553	2,350	0.00	19.61	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	2,825	481	6,009	0.00	9.49	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)				3.63	770.31	27.00
28.00 Observation Bed Days		484	2,203			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	63			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: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Prepared: 5/18/2018 4:09 pm
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Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	1,221	424	2,707	1.00
2.00 HMO and other (see instructions)			77	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,221	424	2,707	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	171	286	691	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet S-3 Part II Date/Time Prepared: 5/18/2018 4:09 pm		
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)			
	1.00	2.00	3.00	4.00	5.00	6.00			
PART II - WAGE DATA									
SALARIES									
1.00	Total salaries (see instructions)	200.00	60,639,721	0	60,639,721	1,602,241.00	37.85		
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00		
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00		
4.00	Physician-Part A - Administrative		1,822,579	0	1,822,579	7,516.00	242.49		
4.01	Physicians - Part A - Teaching		45,908	0	45,908	421.00	109.05		
5.00	Physician and Non-Physician-Part B		20,465,025	0	20,465,025	80,514.00	254.18		
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00		
7.00	Interns & residents (in an approved program)	21.00	0	277,633	277,633	11,682.00	23.77		
7.01	Contracted interns and residents (in an approved programs)		600,606	0	600,606	16,640.00	36.09		
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00		
9.00	SNF	44.00	0	0	0	0.00	0.00		
10.00	Excluded area salaries (see instructions)		1,711,775	0	1,711,775	59,159.00	28.94		
OTHER WAGES & RELATED COSTS									
11.00	Contract Labor: Direct Patient Care		181,992	0	181,992	3,085.07	58.99		
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00		
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00		
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00		
14.01	Home office salaries		0	0	0	0.00	0.00		
14.02	Related organization salaries		0	0	0	0.00	0.00		
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00		
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00		
WAGE-RELATED COSTS									
17.00	Wage-related costs (core) (see instructions)		16,327,071	0	16,327,071				
18.00	Wage-related costs (other) (see instructions)		0	0	0				
19.00	Excluded areas		669,386	0	669,386		19.00		
20.00	Non-physician anesthetist Part A		0	0	0		20.00		
21.00	Non-physician anesthetist Part B		0	0	0		21.00		
22.00	Physician Part A - Administrative		85,044	0	85,044		22.00		
22.01	Physician Part A - Teaching		4,758	0	4,758		22.01		
23.00	Physician Part B		911,027	0	911,027		23.00		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00		
25.00	Interns & residents (in an approved program)		132,183	0	132,183		25.00		
25.50	Home office wage-related (core)		0	0	0		25.50		
25.51	Related organization wage-related (core)		0	0	0		25.51		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		25.52		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		25.53		
OVERHEAD COSTS - DIRECT SALARIES									
26.00	Employee Benefits Department	4.00	1,388,045	0	1,388,045	19,077.00	72.76		
27.00	Administrative & General	5.00	6,730,397	21,902	6,752,299	209,306.00	32.26		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0012

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

Worksheet S-3
Part II
Date/Time Prepared:
5/18/2018 4:09 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	814,955	10,783	825,738	36,819.00	22.43
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	735,998	-134,353	601,645	52,550.00	11.45
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,001,712	-803,703	198,009	13,195.00	15.01
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	803,703	803,703	53,556.00	15.01
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,489,317	-215,173	1,274,144	34,950.00	36.46
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	801,654	0	801,654	22,327.00	35.91
41.00	Medical Records & Medical Records Library	16.00	890,231	-35,865	854,366	40,887.00	20.90
42.00	Social Service	17.00	0	267,996	267,996	9,618.00	27.86
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0012

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

Worksheet S-3
Part III
Date/Time Prepared:
5/18/2018 4:09 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	39,528,182	-277,633	39,250,549	1,492,984.00	26.29	1.00
2.00	Excluded area salaries (see instructions)	1,711,775	0	1,711,775	59,159.00	28.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,816,407	-277,633	37,538,774	1,433,825.00	26.18	3.00
4.00	Subtotal other wages & related costs (see inst.)	181,992	0	181,992	3,085.07	58.99	4.00
5.00	Subtotal wage-related costs (see inst.)	16,412,115	0	16,412,115	0.00	43.72	5.00
6.00	Total (sum of lines 3 thru 5)	54,410,514	-277,633	54,132,881	1,436,910.07	37.67	6.00
7.00	Total overhead cost (see instructions)	13,852,309	-84,710	13,767,599	492,285.00	27.97	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 5/18/2018 4:09 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,281,533 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			232,396 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			14,598 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			9,055,593 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			1,932,551 9.00
10.00	Dental, Hearing and Vision Plan			445,279 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			92,686 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			308,186 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			148,901 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			3,379,830 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			28,688 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			150,000 21.00
22.00	Day Care Cost and Allowances			43,861 22.00
23.00	Tuition Reimbursement			-7,906 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			18,106,196 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/18/2018 4:09 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	782,598	18,129,468	1.00
2.00	Hospital	782,598	17,699,921	2.00
3.00	Subprovider - IPF	0	292,542	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	137,005	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0012 Component CCN: 14-7131		Period: From 01/01/2017 To 12/31/2017		Worksheet S-4 Date/Time Prepared: 5/18/2018 4:09 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			LEE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	987	182	349	1,518	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	174.00	34.00	222.00	430.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.75	0.00	0.75	4.00
5.00	Other Administrative Personnel			1.74	0.00	1.74	5.00
6.00	Direct Nursing Service			6.00	0.00	6.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,041	120	36	6	1,203	21.00
22.00	Skilled Nursing Visit Charges	354,414	37,087	9,411	2,419	403,331	22.00
23.00	Physical Therapy Visits	1,167	12	11	5	1,195	23.00
24.00	Physical Therapy Visit Charges	480,615	5,698	4,072	2,502	492,887	24.00
25.00	Occupational Therapy Visits	148	1	3	0	152	25.00
26.00	Occupational Therapy Visit Charges	66,710	194	1,112	0	68,016	26.00
27.00	Speech Pathology Visits	21	0	1	0	22	27.00
28.00	Speech Pathology Visit Charges	7,840	0	194	0	8,034	28.00
29.00	Medical Social Service Visits	3	0	0	0	3	29.00
30.00	Medical Social Service Visit Charges	1,238	0	0	0	1,238	30.00
31.00	Home Health Aide Visits	234	16	0	0	250	31.00
32.00	Home Health Aide Visit Charges	34,052	1,120	0	0	35,172	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,614	149	51	11	2,825	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	944,869	44,099	14,789	4,921	1,008,678	35.00
36.00	Total Number of Episodes (standard/non outlier)	200		17	1	218	36.00
37.00	Total Number of Outlier Episodes		6		0	6	37.00
38.00	Total Non-Routine Medical Supply Charges	37,562	4,384	3,362	32	45,340	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/18/2018 4:09 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.239319	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,671,680	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?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,726,324	5.00	
6.00	Medicaid charges		48,887,616	6.00	
7.00	Medicaid cost (line 1 times line 6)		11,699,735	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)		6,301,731	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		6,301,731	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)	4,136,255	0	4,136,255	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	989,884	0	989,884	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)	989,884	0	989,884	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)			11,237,956	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			165,175	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			254,114	27.01
28.00	Non-Medicare bad debt expense (see instructions)			10,983,842	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,717,581	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,707,465	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			10,009,196	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,323,587	5,323,587	-762,882	4,560,705	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,548,415	1,548,415	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,388,045	15,050,010	16,438,055	147,631	16,585,686	4.00
5.01	00540	NONPATIENT TELEPHONES	0	3,872	3,872	565,110	568,982	5.01
5.02	00590	DATA PROCESSING	856,488	4,618,504	5,474,992	-564,375	4,910,617	5.02
5.03	00591	PURCHASING RECEIVING AND STORES	367,266	732,475	1,099,741	11,521	1,111,262	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,984,415	2,483,463	4,467,878	10,741	4,478,619	5.04
5.05	00592	OTHER ADMIN & GENERAL	3,522,228	10,196,857	13,719,085	-277,754	13,441,331	5.05
7.00	00700	OPERATION OF PLANT	814,955	2,627,359	3,442,314	-128,767	3,313,547	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	292,159	292,159	0	292,159	8.00
9.00	00900	HOUSEKEEPING	735,998	509,269	1,245,267	-144,631	1,100,636	9.00
10.00	01000	DIETARY	1,001,712	670,530	1,672,242	-1,341,669	330,573	10.00
11.00	01100	CAFETERIA	0	0	0	1,341,669	1,341,669	11.00
13.00	01300	NURSING ADMINISTRATION	1,489,317	376,454	1,865,771	-231,633	1,634,138	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,947,687	3,947,687	-3,910,214	37,473	14.00
15.00	01500	PHARMACY	801,654	2,434,061	3,235,715	-1,672,075	1,563,640	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	890,231	1,928,588	2,818,819	-46,450	2,772,369	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	76,795	76,795	17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	211,449	211,449	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	899,485	899,485	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	97,762	97,762	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,479,680	1,086,469	4,566,149	-179,263	4,386,886	30.00
31.00	03100	INTENSIVE CARE UNIT	957,353	383,652	1,341,005	1,983	1,342,988	31.00
40.00	04000	SUBPROVIDER - IPF	1,043,251	612,265	1,655,516	136	1,655,652	40.00
43.00	04300	NURSERY	357,382	74,632	432,014	2,043	434,057	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,879,865	1,413,203	3,293,068	-271,776	3,021,292	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	182,224	182,224	52.00
53.00	05300	ANESTHESIOLOGY	0	940,397	940,397	-25,517	914,880	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300,751	994,321	2,295,072	2,818	2,297,890	54.00
54.01	05401	ULTRASOUND	365,217	124,271	489,488	1,163	490,651	54.01
57.00	05700	CT SCAN	137,317	305,635	442,952	0	442,952	57.00
58.00	05800	MRI	180,616	202,397	383,013	0	383,013	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,006,048	2,506,904	3,512,952	-2,399,115	1,113,837	59.00
60.00	06000	LABORATORY	2,481,915	2,792,946	5,274,861	3,380	5,278,241	60.00
64.00	06400	INTRAVENOUS THERAPY	0	581,327	581,327	-501,688	79,639	64.00
65.00	06500	RESPIRATORY THERAPY	757,356	223,644	981,000	-153,581	827,419	65.00
66.00	06600	PHYSICAL THERAPY	1,540,884	368,783	1,909,667	-77,656	1,832,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,889	44,964	344,853	43,672	388,525	67.00
68.00	06800	SPEECH PATHOLOGY	283,689	202,827	486,516	-160,609	325,907	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	156,443	156,443	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	240,122	50,847	290,969	212	291,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,807,586	1,807,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,903,506	5,903,506	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,686,255	1,686,255	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	330,704	586,598	917,302	0	917,302	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	552,684	552,684	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	25,184,109	5,516,748	30,700,857	-1,715,635	28,985,222	90.00
91.00	09100	EMERGENCY	4,292,740	1,048,164	5,340,904	-19,306	5,321,598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	488,581	131,522	620,103	-9,689	610,414	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		660,398	660,398	-660,398	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,459,778	72,047,789	132,507,567	0	132,507,567	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	179,943	20,499	200,442	0	200,442	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	289,894	289,894	0	289,894	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	60,639,721	72,358,182	132,997,903	0	132,997,903	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0012

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

Worksheet A
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-605,460	3,955,245	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-24,062	1,524,353	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-13,223	16,572,463	4.00
5.01	00540	NONPATIENT TELEPHONES	-16,185	552,797	5.01
5.02	00590	DATA PROCESSING	0	4,910,617	5.02
5.03	00591	PURCHASING RECEIVING AND STORES	-17,816	1,093,446	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	4,478,619	5.04
5.05	00592	OTHER ADMIN & GENERAL	-3,903,328	9,538,003	5.05
7.00	00700	OPERATION OF PLANT	-406,937	2,906,610	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	292,159	8.00
9.00	00900	HOUSEKEEPING	0	1,100,636	9.00
10.00	01000	DIETARY	0	330,573	10.00
11.00	01100	CAFETERIA	-393,443	948,226	11.00
13.00	01300	NURSING ADMINISTRATION	-10,802	1,623,336	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,473	14.00
15.00	01500	PHARMACY	0	1,563,640	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-81,376	2,690,993	16.00
17.00	01700	SOCIAL SERVICE	0	76,795	17.00
17.01	01701	UTILIZATION REVIEW	-758	210,691	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	899,485	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	97,762	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,386,886	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,342,988	31.00
40.00	04000	SUBPROVIDER - IPF	-517,440	1,138,212	40.00
43.00	04300	NURSERY	0	434,057	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,021,292	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	182,224	52.00
53.00	05300	ANESTHESIOLOGY	-755,474	159,406	53.00
53.01	03950	PAIN MANAGEMENT	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,030	2,296,860	54.00
54.01	05401	ULTRASOUND	0	490,651	54.01
57.00	05700	CT SCAN	0	442,952	57.00
58.00	05800	MRI	0	383,013	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,113,837	59.00
60.00	06000	LABORATORY	-509,670	4,768,571	60.00
64.00	06400	INTRAVENOUS THERAPY	0	79,639	64.00
65.00	06500	RESPIRATORY THERAPY	-900	826,519	65.00
66.00	06600	PHYSICAL THERAPY	0	1,832,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	388,525	67.00
68.00	06800	SPEECH PATHOLOGY	0	325,907	68.00
69.00	06900	ELECTROCARDIOLOGY	0	156,443	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	291,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,807,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,903,506	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,686,255	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-787,430	129,872	76.00
76.97	07697	CARDIAC REHABILITATION	0	552,684	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-19,117,741	9,867,481	90.00
91.00	09100	EMERGENCY	-2,261,380	3,060,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	610,414	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-29,424,455	103,083,112	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	200,442	192.00
194.00	07950	MEALS ON WHEELS	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	289,894	194.01
194.02	07952	IHAP	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-29,424,455	103,573,448	200.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/18/2018 4:09 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DIETARY TO CAFETERIA					
1.00	CAFETERIA	11.00	803,703	537,966	1.00
	O		803,703	537,966	
B - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	112,542	66,731	1.00
	O		112,542	66,731	
C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	605,460	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	24,062	2.00
3.00	OTHER ADMIN & GENERAL	5.05	0	30,876	3.00
	O		0	660,398	
D - COMMUNICATIONS EXPENSE					
1.00	NONPATIENT TELEPHONES	5.01	217,458	347,652	1.00
	O		217,458	347,652	
E - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,793,737	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,903,506	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
	O		0	7,697,243	
F - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,686,255	1.00
	O		0	1,686,255	
H - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	162,301	1.00
	O		0	162,301	
I - PT DIRECTOR SALARY TO OT					
1.00	OCCUPATIONAL THERAPY	67.00	46,217	0	1.00
2.00	SPEECH PATHOLOGY	68.00	15,406	0	2.00
	O		61,623	0	
J - BIO-MED COSTS					
1.00	OTHER ADMIN & GENERAL	5.05	0	313	1.00
2.00	PHARMACY	15.00	0	14,180	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,454	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	3,141	4.00
5.00	SUBPROVIDER - IPF	40.00	0	206	5.00
6.00	NURSERY	43.00	0	2,043	6.00
7.00	OPERATING ROOM	50.00	0	51,705	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,951	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	364	9.00
10.00	LABORATORY	60.00	0	3,010	10.00
11.00	RESPIRATORY THERAPY	65.00	0	11,126	11.00
12.00	PHYSICAL THERAPY	66.00	0	1,326	12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	2,747	13.00
14.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	13,849	14.00
15.00	CLINIC	90.00	0	25,472	15.00
16.00	EMERGENCY	91.00	0	4,378	16.00
17.00	CARDIAC REHABILITATION	76.97	0	1,110	17.00
	O		0	140,375	
K - HOUSEKEEPING					
1.00	DATA PROCESSING	5.02	683	52	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	10,702	819	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	9,978	763	3.00
4.00	OTHER ADMIN & GENERAL	5.05	5,881	450	4.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
5.00	OPERATION OF PLANT	7.00	10,783	825	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	2,509	192	6.00
7.00	ULTRASOUND	54.01	1,172	90	7.00
8.00	LABORATORY	60.00	1,104	84	8.00
9.00	PHYSICAL THERAPY	66.00	5,136	393	9.00
10.00	OCCUPATIONAL THERAPY	67.00	5,135	393	10.00
11.00	SPEECH PATHOLOGY	68.00	656	50	11.00
12.00	CARDIAC REHABILITATION	76.97	4,013	307	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	1,878	144	13.00
14.00	CLINIC	90.00	74,723	5,716	14.00
			134,353	10,278	
L - UTILIZATION REVIEW					
1.00	UTILIZATION REVIEW	17.01	193,358	14,791	1.00
2.00		0.00	0	0	2.00
			193,358	14,791	
M - MEDICAL DIRECTOR					
1.00	UTILIZATION REVIEW	17.01	3,300	0	1.00
			3,300	0	
N - MEDICAL DIRECTOR TIME					
1.00	MEDICAL RECORDS & LIBRARY	16.00	102,506	0	1.00
2.00		0.00	0	0	2.00
			102,506	0	
O - PHYSICIAN PRACTICE AMORTIZATION					
1.00	CLINIC	90.00	0	6,290	1.00
			0	6,290	
P - RESIDENCY COSTS					
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	277,633	621,852	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	45,908	51,854	2.00
			323,541	673,706	
Q - CODER SALARIES					
1.00	CLINIC	90.00	88,848	6,797	1.00
			88,848	6,797	
R - CARDIAC CATH LAB SALARIES					
1.00	CARDIAC REHABILITATION	76.97	331,996	215,258	1.00
			331,996	215,258	
S - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	111,387	45,056	1.00
			111,387	45,056	
U - PATIENT ADVOCATE SALARIES					
1.00	SOCIAL SERVICE	17.00	71,338	5,457	1.00
			71,338	5,457	
V - MOVEABLE EQUIPMENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,475,771	1.00
			0	1,475,771	
X - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	147,631	1.00
	TOTALS		0	147,631	
500.00	Grand Total: Increases		2,555,953	13,899,956	500.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/18/2018 4:09 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	803,703	537,966	0	1.00
	O		803,703	537,966		
B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	112,542	66,731	0	1.00
	O		112,542	66,731		
C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	660,398	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	O		0	660,398		
D - COMMUNICATIONS EXPENSE						
1.00	DATA PROCESSING	5.02	217,458	347,652	0	1.00
	O		217,458	347,652		
E - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,910,214	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,444	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,158	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	70	0	4.00
5.00	OPERATING ROOM	50.00	0	323,481	0	5.00
6.00	ANESTHESIOLOGY	53.00	0	25,517	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	247	0	7.00
8.00	ULTRASOUND	54.01	0	99	0	8.00
9.00	LABORATORY	60.00	0	818	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	8,264	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	22,888	0	11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	8,073	0	12.00
13.00	SPEECH PATHOLOGY	68.00	0	176,721	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	1,854,608	0	14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,810	0	15.00
16.00	CLINIC	90.00	0	833,788	0	16.00
17.00	EMERGENCY	91.00	0	15,666	0	17.00
18.00	HOME HEALTH AGENCY	101.00	0	9,689	0	18.00
19.00	INTRAVENOUS THERAPY	64.00	0	501,688	0	19.00
	O		0	7,697,243		
F - BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	1,686,255	0	1.00
	O		0	1,686,255		
H - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.05	0	162,301	12	1.00
	O		0	162,301		
I - PT DIRECTOR SALARY TO OT						
1.00	PHYSICAL THERAPY	66.00	61,623	0	0	1.00
2.00		0.00	0	0	0	2.00
	O		61,623	0		
J - BIO-MED COSTS						
1.00	OPERATION OF PLANT	7.00	0	140,375	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
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
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
	O		0	140,375		
K - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	134,353	10,278	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
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

		Decreases						
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.			
6.00		7.00	8.00	9.00	10.00			
10.00		0.00	0	0	0		10.00	
11.00		0.00	0	0	0		11.00	
12.00		0.00	0	0	0		12.00	
13.00		0.00	0	0	0		13.00	
14.00		0.00	0	0	0		14.00	
O			134,353	10,278				
L - UTILIZATION REVIEW								
1.00	MEDICAL RECORDS & LIBRARY	16.00	49,523	3,788	0		1.00	
2.00	NURSING ADMINISTRATION	13.00	143,835	11,003	0		2.00	
O			193,358	14,791				
M - MEDICAL DIRECTOR								
1.00	CLINIC	90.00	3,300	0	0		1.00	
O			3,300	0				
N - MEDICAL DIRECTOR TIME								
1.00	CLINIC	90.00	94,488	0	0		1.00	
2.00	EMERGENCY	91.00	8,018	0	0		2.00	
O			102,506	0				
O - PHYSICIAN PRACTICE AMORTIZATION								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,290	9		1.00	
O			0	6,290				
P - RESIDENCY COSTS								
1.00	OTHER ADMIN & GENERAL	5.05	5,342	0	0		1.00	
2.00	CLINIC	90.00	318,199	673,706	0		2.00	
O			323,541	673,706				
Q - CODER SALARIES								
1.00	MEDICAL RECORDS & LIBRARY	16.00	88,848	6,797	0		1.00	
O			88,848	6,797				
R - CARDIAC CATH LAB SALARIES								
1.00	CARDIAC CATHETERIZATION	59.00	331,996	215,258	0		1.00	
O			331,996	215,258				
S - EKG SALARIES								
1.00	RESPIRATORY THERAPY	65.00	111,387	45,056	0		1.00	
O			111,387	45,056				
U - PATIENT ADVOCATE SALARIES								
1.00	NURSING ADMINISTRATION	13.00	71,338	5,457	0		1.00	
O			71,338	5,457				
V - MOVEABLE EQUIPMENT								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,475,771	9		1.00	
O			0	1,475,771				
X - WORKERS COMPENSATION								
1.00	OTHER ADMIN & GENERAL	5.05	0	147,631	0		1.00	
TOTALS			0	147,631				
500.00	Grand Total: Decreases		2,555,953	13,899,956			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,129,972	54,000	0	54,000	0	1.00
2.00	Land Improvements	5,393,440	68,183	0	68,183	3,160	2.00
3.00	Buildings and Fixtures	47,832,461	1,569,241	0	1,569,241	0	3.00
4.00	Building Improvements	19,000	30,578	0	30,578	0	4.00
5.00	Fixed Equipment	30,590,669	1,699,024	0	1,699,024	2,473	5.00
6.00	Movable Equipment	37,034,144	2,101,044	0	2,101,044	1,655,206	6.00
7.00	HIT designated Assets	204,831	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	123,204,517	5,522,070	0	5,522,070	1,660,839	8.00
9.00	Reconciling Items	-626,896	-5,080,531	0	-5,080,531	-5,207,708	9.00
10.00	Total (line 8 minus line 9)	123,831,413	10,602,601	0	10,602,601	6,868,547	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,183,972	0				1.00
2.00	Land Improvements	5,458,463	0				2.00
3.00	Buildings and Fixtures	49,401,702	0				3.00
4.00	Building Improvements	49,578	0				4.00
5.00	Fixed Equipment	32,287,220	0				5.00
6.00	Movable Equipment	37,479,982	0				6.00
7.00	HIT designated Assets	204,831	0				7.00
8.00	Subtotal (sum of lines 1-7)	127,065,748	0				8.00
9.00	Reconciling Items	-499,719	0				9.00
10.00	Total (line 8 minus line 9)	127,565,467	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part II
Date/Time Prepared:
5/18/2018 4:09 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	CAP REL COSTS-BLDG & FIXT	5,323,587	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,323,587	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	5,323,587				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,323,587				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part III
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	89,380,935	0	89,380,935	0.700667	113,719	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	38,184,532	0	38,184,532	0.299333	48,582	2.00
3.00	Total (sum of lines 1-2)	127,565,467	0	127,565,467	1.000000	162,301	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	113,719	3,841,526	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	48,582	1,475,771	0	2.00
3.00	Total (sum of lines 1-2)	0	0	162,301	5,317,297	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 col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	113,719	0	0	3,955,245	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	48,582	0	0	1,524,353	2.00
3.00	Total (sum of lines 1-2)	0	162,301	0	0	5,479,598	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0012

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

Worksheet A-8

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-605,460	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-24,062	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00 Investment income - other (chapter 2)	B	-30,876	OTHER ADMIN & GENERAL	5.05	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-17,816	PURCHASING RECEIVING AND STORES	5.03	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-28,954	OTHER ADMIN & GENERAL	5.05	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-16,185	NONPATIENT TELEPHONES	5.01	0	7.00
8.00 Television and radio service (chapter 21)	A	-25,226	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-23,985,182			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-393,443	CAFETERIA	11.00	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	B	-46,987	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MISCELLANEOUS INCOME	B	-107,963	OTHER ADMIN & GENERAL	5.05	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0012

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

Worksheet A-8

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 NONALLOWABLE COSTS	A	-214,490	OTHER ADMIN & GENERAL	5.05	0	35.00
36.00 EDUCATION REV (LIFE SUPPORT, CARE CO)	B	-10,802	NURSING ADMINISTRATION	13.00	0	36.00
37.00 SALE OF RADIOLOGY COPIES	B	-1,030	RADIOLOGY-DIAGNOSTIC	54.00	0	37.00
38.00 ADVERTISING	A	-81,281	OTHER ADMIN & GENERAL	5.05	0	38.00
40.00 FINES & PENALTIES	A	-135,390	OTHER ADMIN & GENERAL	5.05	0	40.00
40.01 RENTAL REVENUE	B	-381,711	OPERATION OF PLANT	7.00	0	40.01
40.02 AHA & IHA LOBBYING DUES	A	-28,829	OTHER ADMIN & GENERAL	5.05	0	40.02
41.00 EMPLOYEE PHYSICALS	A	-13,223	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00 PHYSICIAN RECRUITMENT COSTS	A	-227,425	OTHER ADMIN & GENERAL	5.05	0	42.00
43.00 IPA TAX	A	-3,048,120	OTHER ADMIN & GENERAL	5.05	0	43.00
44.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
44.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,424,455				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: 14-0012

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

Worksheet A-8-2

Date/Time Prepared:
5/18/2018 4:09 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	16.00	MEDICAL RECORDS & LIBRARY	102,506	0	102,506	211,500	638	1.00
2.00	17.01	UTILIZATION REVIEW	3,300	0	3,300	211,500	25	2.00
3.00	40.00	SUBPROVIDER - IPF	517,440	517,440	0	181,300	0	3.00
4.00	53.00	ANESTHESIOLOGY	755,474	755,474	0	239,400	0	4.00
5.00	60.00	LABORATORY	602,241	500,037	102,204	260,300	708	5.00
6.00	65.00	RESPIRATORY THERAPY	900	900	0	211,500	0	6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	787,430	787,430	0	181,300	0	7.00
8.00	90.00	CLINIC	19,287,780	19,096,941	190,839	211,500	1,615	8.00
9.00	91.00	EMERGENCY	2,745,484	1,321,754	1,423,730	211,500	4,530	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			24,802,555	22,979,976	1,822,579		7,516	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	16.00	MEDICAL RECORDS & LIBRARY	64,874	3,244	3,243	3,243	0	1.00
2.00	17.01	UTILIZATION REVIEW	2,542	127	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	3,598	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	88,602	4,430	21,171	3,593	2,214	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	1,934	0	0	6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,731	0	0	7.00
8.00	90.00	CLINIC	164,217	8,211	137,949	1,365	450,509	8.00
9.00	91.00	EMERGENCY	460,623	23,031	29,205	15,145	16,074	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			780,858	39,043	198,831	23,346	468,797	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	16.00	MEDICAL RECORDS & LIBRARY	0	68,117	34,389	34,389		1.00
2.00	17.01	UTILIZATION REVIEW	0	2,542	758	758		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	517,440		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	755,474		4.00
5.00	60.00	LABORATORY	376	92,571	9,633	509,670		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	900		6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	787,430		7.00
8.00	90.00	CLINIC	4,457	170,039	20,800	19,117,741		8.00
9.00	91.00	EMERGENCY	8,336	484,104	939,626	2,261,380		9.00
10.00	0.00		0	0	0	0		10.00
200.00			13,169	817,373	1,005,206	23,985,182		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,955,245	3,955,245			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,524,353		1,524,353		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,572,463	39,955	2,567	16,614,985	4.00
5.01 00540	NONPATIENT TELEPHONES	552,797	4,432	0	60,978	618,207 5.01
5.02 00590	DATA PROCESSING	4,910,617	70,394	312,022	179,384	23,558 5.02
5.03 00591	PURCHASING RECEIVING AND STORES	1,093,446	107,644	10,140	105,988	7,139 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,478,619	109,454	3,881	559,256	40,690 5.04
5.05 00592	OTHER ADMIN & GENERAL	9,538,003	105,908	34,810	987,833	39,263 5.05
7.00 00700	OPERATION OF PLANT	2,906,610	1,209,416	39,326	231,548	27,127 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	292,159	1,601	0	0	0 8.00
9.00 00900	HOUSEKEEPING	1,100,636	35,278	0	168,710	2,142 9.00
10.00 01000	DIETARY	330,573	48,983	2,937	55,524	12,136 10.00
11.00 01100	CAFETERIA	948,226	32,936	11,917	225,370	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,623,336	23,248	143,224	357,288	10,708 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	37,473	5,753	813	0	1,428 14.00
15.00 01500	PHARMACY	1,563,640	23,211	40,882	224,795	7,853 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,690,993	45,509	26,361	239,576	13,563 16.00
17.00 01700	SOCIAL SERVICE	76,795	0	0	20,004	0 17.00
17.01 01701	UTILIZATION REVIEW	210,691	1,257	0	55,146	2,142 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	899,485	0	0	77,852	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	97,762	0	0	12,873	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,386,886	390,894	76,323	944,193	24,985 30.00
31.00 03100	INTENSIVE CARE UNIT	1,342,988	40,145	36,152	268,455	7,853 31.00
40.00 04000	SUBPROVIDER - I PF	1,138,212	57,920	4,094	292,542	8,566 40.00
43.00 04300	NURSERY	434,057	3,763	6,569	100,215	1,428 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,021,292	244,896	216,837	527,140	27,841 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	182,224	11,271	5,395	31,558	714 52.00
53.00 05300	ANESTHESIOLOGY	159,406	769	21,478	0	0 53.00
53.01 03950	PAIN MANAGEMENT	0	0	0	0	0 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,296,860	64,143	118,042	365,452	14,991 54.00
54.01 05401	ULTRASOUND	490,651	2,569	757	102,741	1,428 54.01
57.00 05700	CT SCAN	442,952	5,129	2,585	38,506	1,428 57.00
58.00 05800	MRI	383,013	4,487	6,990	50,647	1,428 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,113,837	49,272	46,433	189,014	3,569 59.00
60.00 06000	LABORATORY	4,768,571	50,349	138,313	696,273	19,988 60.00
64.00 06400	INTRAVENOUS THERAPY	79,639	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	826,519	11,398	52,474	181,139	6,425 65.00
66.00 06600	PHYSICAL THERAPY	1,832,011	80,598	15,759	416,246	14,991 66.00
67.00 06700	OCCUPATIONAL THERAPY	388,525	0	0	98,493	2,142 67.00
68.00 06800	SPEECH PATHOLOGY	325,907	15,830	685	84,054	2,855 68.00
69.00 06900	ELECTROCARDIOLOGY	156,443	1,266	0	31,234	1,428 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	291,181	14,745	6,572	67,860	1,428 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	1,807,586	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,903,506	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,686,255	0	0	0	0 73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	129,872	25,798	493	92,734	7,853 76.00
76.97 07697	CARDIAC REHABILITATION	552,684	0	0	94,222	1,428 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	9,867,481	843,941	106,785	6,991,182	239,854 90.00
91.00 09100	EMERGENCY	3,060,218	126,903	31,887	1,201,496	27,127 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	610,414	33,153	850	137,005	8,566 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	103,083,112	3,944,218	1,524,353	16,564,526	616,065 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	11,027	0	0	2,142 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	200,442	0	0	50,459	0 192.00
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
194.01 07951	RETAIL PHARMACY	289,894	0	0	0	0 194.01
194.02 07952	I HAP	0	0	0	0	0 194.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	103,573,448	3,955,245	1,524,353	16,614,985	618,207 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	DATA PROCESSING	5,495,975					5.02
5.03	00591	PURCHASING RECEIVING AND STORES	93,948	1,418,305				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	301,977	1,314	5,495,191			5.04
5.05	00592	OTHER ADMIN & GENERAL	369,083	32,485	0	11,107,385	11,107,385	5.05
7.00	00700	OPERATION OF PLANT	73,817	48,048	0	4,535,892	544,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	293,760	35,288	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,306,766	156,974	9.00
10.00	01000	DIETARY	46,974	732	0	497,859	59,805	10.00
11.00	01100	CAFETERIA	0	2,969	0	1,221,418	146,722	11.00
13.00	01300	NURSING ADMINISTRATION	275,134	1,173	0	2,434,111	292,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,421	0	0	58,888	7,074	14.00
15.00	01500	PHARMACY	87,238	1,036	0	1,948,655	234,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	154,344	5,768	0	3,176,114	381,528	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	96,799	11,628	17.00
17.01	01701	UTILIZATION REVIEW	26,842	0	0	296,078	35,566	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	977,337	117,402	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	67,106	0	0	177,741	21,351	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	221,450	30,033	181,309	6,256,073	751,505	30.00
31.00	03100	INTENSIVE CARE UNIT	53,685	7,589	160,317	1,917,184	230,300	31.00
40.00	04000	SUBPROVIDER - I/PF	46,974	1,083	76,593	1,625,984	195,320	40.00
43.00	04300	NURSERY	0	7,158	13,742	566,932	68,102	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	241,581	108,304	560,430	4,948,321	594,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,784	18,589	251,535	30,215	52.00
53.00	05300	ANESTHESIOLOGY	0	11,735	85,940	279,328	33,554	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,369	32,885	189,062	3,188,804	383,052	54.00
54.01	05401	ULTRASOUND	0	2,521	97,428	698,095	83,858	54.01
57.00	05700	CT SCAN	6,711	12,168	368,121	877,600	105,421	57.00
58.00	05800	MRI	20,132	20,049	127,011	613,757	73,727	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,948	177,650	360,471	2,034,194	244,356	59.00
60.00	06000	LABORATORY	208,028	185,728	550,386	6,617,636	794,937	60.00
64.00	06400	INTRAVENOUS THERAPY	0	17,454	69,153	166,246	19,970	64.00
65.00	06500	RESPIRATORY THERAPY	46,974	13,684	114,982	1,253,595	150,587	65.00
66.00	06600	PHYSICAL THERAPY	167,765	4,385	166,180	2,697,935	324,087	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,133	23,067	513,360	61,667	67.00
68.00	06800	SPEECH PATHOLOGY	40,264	21,837	19,295	510,727	61,351	68.00
69.00	06900	ELECTROCARDIOLOGY	40,264	2,597	35,986	269,218	32,340	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,553	2,497	40,990	458,826	55,116	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	416,036	409,128	2,632,750	316,256	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	87,846	5,991,352	719,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	605,814	2,292,069	275,332	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	73,817	113	15,066	345,746	41,532	76.00
76.97	07697	CARDIAC REHABILITATION	0	87,499	11,639	747,472	89,789	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,315,152	128,059	810,466	21,302,920	2,558,981	90.00
91.00	09100	EMERGENCY	181,186	28,035	282,536	4,939,388	593,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	87,238	2,764	12,085	892,075	107,160	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,495,975	1,418,305	5,493,632	103,017,925	11,040,653	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	13,169	1,582	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,559	252,460	30,327	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	289,894	34,823	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,495,975	1,418,305	5,495,191	103,573,448	11,107,385	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00590	DATA PROCESSING					5.02
5.03	00591	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00592	OTHER ADMIN & GENERAL					5.05
7.00	00700	OPERATION OF PLANT	5,080,761				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,525	332,573			8.00
9.00	00900	HOUSEKEEPING	77,659	0	1,541,399		9.00
10.00	01000	DIETARY	107,827	0	10,360	675,851	10.00
11.00	01100	CAFETERIA	72,502	0	24,420	0	1,465,062
13.00	01300	NURSING ADMINISTRATION	51,176	0	7,400	0	35,733
14.00	01400	CENTRAL SERVICES & SUPPLY	12,664	0	17,760	0	3,573
15.00	01500	PHARMACY	51,096	0	19,240	0	39,307
16.00	01600	MEDICAL RECORDS & LIBRARY	100,181	0	47,359	0	60,746
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	2,768	0	1,480	0	10,720
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	39,307
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	860,487	105,787	338,915	349,857	175,093
31.00	03100	INTENSIVE CARE UNIT	88,372	16,635	41,439	47,031	46,453
40.00	04000	SUBPROVIDER - I/PF	127,501	9,348	48,839	85,969	53,600
43.00	04300	NURSERY	8,284	4,535	8,880	0	10,720
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	539,096	71,655	295,996	17,736	125,066
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,811	2,749	19,240	0	3,573
53.00	05300	ANESTHESIOLOGY	1,693	0	0	0	0
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,201	8,168	56,979	0	71,466
54.01	05401	ULTRASOUND	5,655	4,240	2,960	0	17,867
57.00	05700	CT SCAN	11,290	15,845	5,920	0	7,147
58.00	05800	MRI	9,877	5,507	5,180	0	10,720
59.00	05900	CARDIAC CATHETERIZATION	108,464	3,425	17,020	0	32,160
60.00	06000	LABORATORY	110,834	0	45,879	0	110,773
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	25,090	0	62,899	0	28,587
66.00	06600	PHYSICAL THERAPY	177,422	15,315	62,159	0	60,746
67.00	06700	OCCUPATIONAL THERAPY	0	0	19,240	0	14,293
68.00	06800	SPEECH PATHOLOGY	34,847	0	8,880	0	14,293
69.00	06900	ELECTROCARDIOLOGY	2,788	0	3,700	0	21,440
70.00	07000	ELECTROENCEPHALOGRAPHY	32,458	0	7,400	0	7,147
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,791	0	9,620	0	21,440
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,857,793	0	128,758	0	293,012
91.00	09100	EMERGENCY	279,355	69,364	195,357	0	117,920
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	72,980	0	14,800	0	32,160
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,056,487	332,573	1,528,079	500,593	1,465,062
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	24,274	0	13,320	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MEALS ON WHEELS	0	0	0	175,258	0
194.01	07951	RETAIL PHARMACY	0	0	0	0	0
194.02	07952	I/HAP	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	5,080,761	332,573	1,541,399	675,851	1,465,062

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/18/2018 4:09 pm	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	DATA PROCESSING						5.02
5.03	00591	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00592	OTHER ADMIN & GENERAL						5.05
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	2,820,815					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	99,959				14.00
15.00	01500	PHARMACY	0	0	2,292,378			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,765,928		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	108,427	17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	460,968	0	3,049	352,782	65,648	30.00
31.00	03100	INTENSIVE CARE UNIT	125,408	0	482	396,565	13,666	31.00
40.00	04000	SUBPROVIDER - IPF	136,331	0	67	189,462	23,255	40.00
43.00	04300	NURSERY	33,856	0	0	33,992	5,858	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	228,436	0	6,517	356,112	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,359	0	43	29,362	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	62,154	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,428	41,110	0	54.00
54.01	05401	ULTRASOUND	0	0	227	21,398	0	54.01
57.00	05700	CT SCAN	0	0	234	161,206	0	57.00
58.00	05800	MRI	0	0	831	15,066	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	128,120	0	1,563	246,649	0	59.00
60.00	06000	LABORATORY	0	0	977	341,751	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	324,875	115,360	0	64.00
65.00	06500	RESPIRATORY THERAPY	79,782	0	18,083	229,390	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	227	27,110	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,690	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,873	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,316	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,112	0	0	375	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	23,293	0	351,257	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	76,666	0	24,794	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,094,064	565,769	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	41,024	0	0	26,907	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,252,098	0	765,355	1,342	0	90.00
91.00	09100	EMERGENCY	226,668	0	1,285	148,136	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	65,653	0	157	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,820,815	99,959	2,225,464	3,765,928	108,427	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	66,914	0	0	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,820,815	99,959	2,292,378	3,765,928	108,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A			
	17.01	21.00	22.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	DATA PROCESSING					5.02
5.03 00591	PURCHASING RECEIVING AND STORES					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00592	OTHER ADMIN & GENERAL					5.05
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01701	UTILIZATION REVIEW	346,612				17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	1,094,739			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0		238,399		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	209,859	843,790	183,751	10,957,564	-1,097,478
31.00 03100	INTENSIVE CARE UNIT	43,686	175,652	38,251	3,181,124	-213,903
40.00 04000	SUBPROVIDER - I/PF	74,340	0	0	2,570,016	0
43.00 04300	NURSERY	18,727	75,297	16,397	851,580	-91,694
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	7,183,347	-189,413
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	372,887	0
53.00 05300	ANESTHESIOLOGY	0	0	0	376,729	0
53.01 03950	PAIN MANAGEMENT	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,898,208	0
54.01 05401	ULTRASOUND	0	0	0	834,300	0
57.00 05700	CT SCAN	0	0	0	1,184,663	0
58.00 05800	MRI	0	0	0	734,665	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	2,815,951	0
60.00 06000	LABORATORY	0	0	0	8,022,787	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	626,451	1,028,081
65.00 06500	RESPIRATORY THERAPY	0	0	0	1,848,013	0
66.00 06600	PHYSICAL THERAPY	0	0	0	3,365,001	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	618,250	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	633,971	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	343,802	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	592,434	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,323,556	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,812,517	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,227,234	0
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	543,060	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	837,261	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	28,160,259	-9,558
91.00 09100	EMERGENCY	0	0	0	6,570,812	-759,173
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	1,184,985	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	346,612	1,094,739	238,399	102,671,427	-1,333,138
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	52,345	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	282,787	0
194.00 07950	MEALS ON WHEELS	0	0	0	175,258	0
194.01 07951	RETAIL PHARMACY	0	0	0	391,631	0
194.02 07952	IHAP	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	346,612	1,094,739	238,399	103,573,448	-1,333,138

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00590	DATA PROCESSING	5.02
5.03	00591	PURCAHSING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00592	OTHER ADMIN & GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
17.01	01701	UTILIZATION REVIEW	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
53.01	03950	PAIN MANAGEMENT	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MEALS ON WHEELS	194.00
194.01	07951	RETAIL PHARMACY	194.01
194.02	07952	IHAP	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2018 4:09 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00				2.00
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400	0	39,955	2,567	42,522	42,522	4.00	
5.01	00540	0	4,432	0	4,432	156	5.01	
5.02	00590	0	70,394	312,022	382,416	459	5.02	
5.03	00591	198,739	107,644	10,140	316,523	271	5.03	
5.04	00580	0	109,454	3,881	113,335	1,432	5.04	
5.05	00592	-36,481	105,908	34,810	104,237	2,529	5.05	
7.00	00700	124,679	1,209,416	39,326	1,373,421	593	7.00	
8.00	00800	0	1,601	0	1,601	0	8.00	
9.00	00900	0	35,278	0	35,278	432	9.00	
10.00	01000	0	48,983	2,937	51,920	142	10.00	
11.00	01100	0	32,936	11,917	44,853	577	11.00	
13.00	01300	0	23,248	143,224	166,472	915	13.00	
14.00	01400	0	5,753	813	6,566	0	14.00	
15.00	01500	114,468	23,211	40,882	178,561	576	15.00	
16.00	01600	0	45,509	26,361	71,870	613	16.00	
17.00	01700	0	0	0	0	51	17.00	
17.01	01701	0	1,257	0	1,257	141	17.01	
21.00	02100	0	0	0	0	199	21.00	
22.00	02200	0	0	0	0	33	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	10,491	390,894	76,323	477,708	2,418	30.00	
31.00	03100	2,524	40,145	36,152	78,821	687	31.00	
40.00	04000	0	57,920	4,094	62,014	749	40.00	
43.00	04300	360	3,763	6,569	10,692	257	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	370,929	244,896	216,837	832,662	1,350	50.00	
52.00	05200	0	11,271	5,395	16,666	81	52.00	
53.00	05300	4,180	769	21,478	26,427	0	53.00	
53.01	03950	0	0	0	0	0	53.01	
54.00	05400	4,386	64,143	118,042	186,571	936	54.00	
54.01	05401	58,817	2,569	757	62,143	263	54.01	
57.00	05700	24,800	5,129	2,585	32,514	99	57.00	
58.00	05800	0	4,487	6,990	11,477	130	58.00	
59.00	05900	0	49,272	46,433	95,705	484	59.00	
60.00	06000	73,303	50,349	138,313	261,965	1,783	60.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	887	11,398	52,474	64,759	464	65.00	
66.00	06600	19,382	80,598	15,759	115,739	1,066	66.00	
67.00	06700	0	0	0	0	252	67.00	
68.00	06800	0	15,830	685	16,515	215	68.00	
69.00	06900	0	1,266	0	1,266	80	69.00	
70.00	07000	197	14,745	6,572	21,514	174	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	0	73.00	
76.00	03550	0	25,798	493	26,291	237	76.00	
76.97	07697	0	0	0	0	241	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	429,602	843,941	106,785	1,380,328	17,881	90.00	
91.00	09100	0	126,903	31,887	158,790	3,076	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	33,153	850	34,003	351	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		1,401,263	3,944,218	1,524,353	6,869,834	42,393	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	11,027	0	11,027	0	190.00	
192.00	19200	0	0	0	0	129	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)		1,401,263	3,955,245	1,524,353	6,880,861	42,522	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/18/2018 4:09 pm	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	4,588					5.01
5.02	00590	DATA PROCESSING	175	383,050				5.02
5.03	00591	PURCHASING RECEIVING AND STORES	53	6,548	323,395			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	302	21,047	300	136,416		5.04
5.05	00592	OTHER ADMIN & GENERAL	291	25,724	7,407	0	140,188	5.05
7.00	00700	OPERATION OF PLANT	201	5,145	10,956	0	6,876	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	445	8.00
9.00	00900	HOUSEKEEPING	16	0	0	0	1,981	9.00
10.00	01000	DIETARY	90	3,274	167	0	755	10.00
11.00	01100	CAFETERIA	0	0	677	0	1,852	11.00
13.00	01300	NURSING ADMINISTRATION	79	19,176	268	0	3,690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11	935	0	0	89	14.00
15.00	01500	PHARMACY	58	6,080	236	0	2,954	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101	10,757	1,315	0	4,815	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	147	17.00
17.01	01701	UTILIZATION REVIEW	16	1,871	0	0	449	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	1,482	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	4,677	0	0	269	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	185	15,434	6,848	4,500	9,484	30.00
31.00	03100	INTENSIVE CARE UNIT	58	3,742	1,730	3,979	2,906	31.00
40.00	04000	SUBPROVIDER - IPF	64	3,274	247	1,901	2,465	40.00
43.00	04300	NURSERY	11	0	1,632	341	859	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	207	16,837	24,695	13,910	7,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5	0	407	461	381	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,676	2,133	423	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	111	7,483	7,498	4,692	4,834	54.00
54.01	05401	ULTRASOUND	11	0	575	2,418	1,058	54.01
57.00	05700	CT SCAN	11	468	2,774	9,137	1,330	57.00
58.00	05800	MRI	11	1,403	4,571	3,152	930	58.00
59.00	05900	CARDIAC CATHETERIZATION	26	6,548	40,507	8,947	3,084	59.00
60.00	06000	LABORATORY	148	14,499	42,349	13,660	10,032	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,980	1,716	252	64.00
65.00	06500	RESPIRATORY THERAPY	48	3,274	3,120	2,854	1,900	65.00
66.00	06600	PHYSICAL THERAPY	111	11,693	1,000	4,125	4,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	16	0	258	573	778	67.00
68.00	06800	SPEECH PATHOLOGY	21	2,806	4,979	479	774	68.00
69.00	06900	ELECTROCARDIOLOGY	11	2,806	592	893	408	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11	2,339	569	1,017	696	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	94,863	10,154	3,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,180	9,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,036	3,475	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	58	5,145	26	374	524	76.00
76.97	07697	CARDIAC REHABILITATION	11	0	19,951	289	1,133	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,779	161,357	29,200	20,144	32,310	90.00
91.00	09100	EMERGENCY	201	12,628	6,392	7,012	7,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	64	6,080	630	300	1,352	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,572	383,050	323,395	136,377	139,346	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	16	0	0	0	20	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	39	383	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	439	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,588	383,050	323,395	136,416	140,188	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00590	DATA PROCESSING					5.02
5.03	00591	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00592	OTHER ADMIN & GENERAL					5.05
7.00	00700	OPERATION OF PLANT	1,397,192				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	969	3,015			8.00
9.00	00900	HOUSEKEEPING	21,356	0	59,063		9.00
10.00	01000	DIETARY	29,652	0	397	86,397	10.00
11.00	01100	CAFETERIA	19,938	0	936	0	68,833
13.00	01300	NURSING ADMINISTRATION	14,073	0	284	0	1,679
14.00	01400	CENTRAL SERVICES & SUPPLY	3,483	0	681	0	168
15.00	01500	PHARMACY	14,051	0	737	0	1,847
16.00	01600	MEDICAL RECORDS & LIBRARY	27,549	0	1,815	0	2,854
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	761	0	57	0	504
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	1,847
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	236,631	958	12,986	44,724	8,226
31.00	03100	INTENSIVE CARE UNIT	24,302	151	1,588	6,012	2,183
40.00	04000	SUBPROVIDER - IPF	35,062	85	1,871	10,990	2,518
43.00	04300	NURSERY	2,278	41	340	0	504
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	148,250	650	11,342	2,267	5,876
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,823	25	737	0	168
53.00	05300	ANESTHESIOLOGY	465	0	0	0	0
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,830	74	2,183	0	3,358
54.01	05401	ULTRASOUND	1,555	38	113	0	839
57.00	05700	CT SCAN	3,105	144	227	0	336
58.00	05800	MRI	2,716	50	198	0	504
59.00	05900	CARDIAC CATHETERIZATION	29,827	31	652	0	1,511
60.00	06000	LABORATORY	30,479	0	1,758	0	5,204
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	6,900	0	2,410	0	1,343
66.00	06600	PHYSICAL THERAPY	48,790	139	2,382	0	2,854
67.00	06700	OCCUPATIONAL THERAPY	0	0	737	0	672
68.00	06800	SPEECH PATHOLOGY	9,583	0	340	0	672
69.00	06900	ELECTROCARDIOLOGY	767	0	142	0	1,007
70.00	07000	ELECTROENCEPHALOGRAPHY	8,926	0	284	0	336
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	15,617	0	369	0	1,007
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	510,888	0	4,934	0	13,765
91.00	09100	EMERGENCY	76,822	629	7,486	0	5,540
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	20,069	0	567	0	1,511
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,390,517	3,015	58,553	63,993	68,833
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	6,675	0	510	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MEALS ON WHEELS	0	0	0	22,404	0
194.01	07951	RETAIL PHARMACY	0	0	0	0	0
194.02	07952	IHAP	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,397,192	3,015	59,063	86,397	68,833

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580						5.04
5.05	00592						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	206,636					13.00
14.00	01400	0	11,933				14.00
15.00	01500	0	0	205,100			15.00
16.00	01600	0	0	0	121,689		16.00
17.00	01700	0	0	0	0	198	17.00
17.01	01701	0	0	0	0	0	17.01
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,768	0	273	11,402	120	30.00
31.00	03100	9,187	0	43	12,817	25	31.00
40.00	04000	9,987	0	6	6,123	42	40.00
43.00	04300	2,480	0	0	1,099	11	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,734	0	583	11,510	0	50.00
52.00	05200	832	0	4	949	0	52.00
53.00	05300	0	0	0	2,009	0	53.00
53.01	03950	0	0	0	0	0	53.01
54.00	05400	0	0	665	1,329	0	54.00
54.01	05401	0	0	20	692	0	54.01
57.00	05700	0	0	21	5,210	0	57.00
58.00	05800	0	0	74	487	0	58.00
59.00	05900	9,385	0	140	7,972	0	59.00
60.00	06000	0	0	87	11,045	0	60.00
64.00	06400	0	0	29,067	3,728	0	64.00
65.00	06500	5,844	0	1,618	7,414	0	65.00
66.00	06600	0	0	20	876	0	66.00
67.00	06700	0	0	0	313	0	67.00
68.00	06800	0	0	0	125	0	68.00
69.00	06900	0	0	0	463	0	69.00
70.00	07000	2,279	0	0	12	0	70.00
71.00	07100	0	2,780	0	11,353	0	71.00
72.00	07200	0	9,153	0	801	0	72.00
73.00	07300	0	0	97,886	18,259	0	73.00
76.00	03550	3,005	0	0	870	0	76.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	91,722	0	68,477	43	0	90.00
91.00	09100	16,604	0	115	4,788	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,809	0	14	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		206,636	11,933	199,113	121,689	198	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	5,987	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		206,636	11,933	205,100	121,689	198	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A			
	17.01	21.00	22.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	DATA PROCESSING					5.02
5.03 00591	PURCHASING RECEIVING AND STORES					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00592	OTHER ADMIN & GENERAL					5.05
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01701	UTILIZATION REVIEW	5,056				17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	1,681			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0		6,826		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,062		868,727	0	30.00
31.00 03100	INTENSIVE CARE UNIT	637		148,868	0	31.00
40.00 04000	SUBPROVIDER - I PF	1,084		138,482	0	40.00
43.00 04300	NURSERY	273		20,818	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0		1,094,375	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0		27,539	0	52.00
53.00 05300	ANESTHESIOLOGY	0		34,133	0	53.00
53.01 03950	PAIN MANAGEMENT	0		0	0	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0		258,564	0	54.00
54.01 05401	ULTRASOUND	0		69,725	0	54.01
57.00 05700	CT SCAN	0		55,376	0	57.00
58.00 05800	MRI	0		25,703	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0		204,819	0	59.00
60.00 06000	LABORATORY	0		393,009	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0		38,743	0	64.00
65.00 06500	RESPIRATORY THERAPY	0		101,948	0	65.00
66.00 06600	PHYSICAL THERAPY	0		192,885	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0		3,599	0	67.00
68.00 06800	SPEECH PATHOLOGY	0		36,509	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0		8,435	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0		38,157	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0		123,141	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0		21,217	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0		134,656	0	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		53,523	0	76.00
76.97 07697	CARDIAC REHABILITATION	0		21,625	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0		2,332,828	0	90.00
91.00 09100	EMERGENCY	0		307,571	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0		69,750	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5,056	0	6,824,725	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0		18,248	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0		551	0	192.00
194.00 07950	MEALS ON WHEELS	0		22,404	0	194.00
194.01 07951	RETAIL PHARMACY	0		6,426	0	194.01
194.02 07952	I HAP	0		0	0	194.02
200.00	Cross Foot Adjustments		1,681	6,826	8,507	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,056	1,681	6,826	6,880,861	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00590	DATA PROCESSING	5.02
5.03	00591	PURCAHSING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00592	OTHER ADMIN & GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
17.01	01701	UTILIZATION REVIEW	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
53.01	03950	PAIN MANAGEMENT	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MEALS ON WHEELS	194.00
194.01	07951	RETAIL PHARMACY	194.01
194.02	07952	IHAP	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	437,249				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,475,771			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,417	2,485	59,251,677		4.00
5.01 00540	NONPATIENT TELEPHONES	490	0	217,458	866	5.01
5.02 00590	DATA PROCESSING	7,782	302,076	639,713	33	819 5.02
5.03 00591	PURCAHSING RECEIVING AND STORES	11,900	9,817	377,968	10	14 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	12,100	3,757	1,994,393	57	45 5.04
5.05 00592	OTHER ADMIN & GENERAL	11,708	33,701	3,522,767	55	55 5.05
7.00 00700	OPERATION OF PLANT	133,700	38,073	825,738	38	11 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	177	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	3,900	0	601,645	3	0 9.00
10.00 01000	DIETARY	5,415	2,843	198,009	17	7 10.00
11.00 01100	CAFETERIA	3,641	11,537	803,703	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	2,570	138,659	1,274,144	15	41 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	636	787	0	2	2 14.00
15.00 01500	PHARMACY	2,566	39,579	801,654	11	13 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,031	25,521	854,367	19	23 16.00
17.00 01700	SOCIAL SERVICE	0	0	71,338	0	0 17.00
17.01 01701	UTILIZATION REVIEW	139	0	196,658	3	4 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	277,633	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	45,908	0	10 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	43,213	73,891	3,367,138	35	33 30.00
31.00 03100	INTENSIVE CARE UNIT	4,438	35,000	957,353	11	8 31.00
40.00 04000	SUBPROVIDER - I PF	6,403	3,964	1,043,251	12	7 40.00
43.00 04300	NURSERY	416	6,360	357,382	2	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	27,073	209,926	1,879,865	39	36 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,246	5,223	112,542	1	0 52.00
53.00 05300	ANESTHESIOLOGY	85	20,793	0	0	0 53.00
53.01 03950	PAIN MANAGEMENT	0	0	0	0	0 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,091	114,280	1,303,260	21	16 54.00
54.01 05401	ULTRASOUND	284	733	366,389	2	0 54.01
57.00 05700	CT SCAN	567	2,503	137,317	2	1 57.00
58.00 05800	MRI	496	6,767	180,616	2	3 58.00
59.00 05900	CARDIAC CATHETERIZATION	5,447	44,953	674,052	5	14 59.00
60.00 06000	LABORATORY	5,566	133,905	2,483,019	28	31 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	1,260	50,802	645,969	9	7 65.00
66.00 06600	PHYSICAL THERAPY	8,910	15,257	1,484,397	21	25 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	351,241	3	0 67.00
68.00 06800	SPEECH PATHOLOGY	1,750	663	299,751	4	6 68.00
69.00 06900	ELECTROCARDIOLOGY	140	0	111,387	2	6 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,630	6,363	242,000	2	5 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,852	477	330,704	11	11 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	336,009	2	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	93,297	103,382	24,931,693	336	345 90.00
91.00 09100	EMERGENCY	14,029	30,871	4,284,722	38	27 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,665	823	488,581	12	13 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	436,030	1,475,771	59,071,734	863	819 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	1,219	0	0	3	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	179,943	0	0 192.00
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
194.01 07951	RETAIL PHARMACY	0	0	0	0	0 194.01
194.02 07952	I HAP	0	0	0	0	0 194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,955,245	1,524,353	16,614,985	618,207	5,495,975 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	9.045750	1.032920	0.280414	713.864896	6,710.592186	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			42,522	4,588	383,050	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000718	5.297921	467.704518	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: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591	11,750,846					5.03
5.04	00580	10,886	450,125,108				5.04
5.05	00592	269,146	0	-11,107,385	92,466,063		5.05
7.00	00700	398,083	0	0	4,535,892	255,152	7.00
8.00	00800	0	0	0	293,760	177	8.00
9.00	00900	0	0	0	1,306,766	3,900	9.00
10.00	01000	6,061	0	0	497,859	5,415	10.00
11.00	01100	24,601	0	0	1,221,418	3,641	11.00
13.00	01300	9,720	0	0	2,434,111	2,570	13.00
14.00	01400	0	0	0	58,888	636	14.00
15.00	01500	8,584	0	0	1,948,655	2,566	15.00
16.00	01600	47,792	0	0	3,176,114	5,031	16.00
17.00	01700	0	0	0	96,799	0	17.00
17.01	01701	0	0	0	296,078	139	17.01
21.00	02100	0	0	0	977,337	0	21.00
22.00	02200	0	0	0	177,741	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	248,824	14,851,659	0	6,256,073	43,213	30.00
31.00	03100	62,877	13,132,163	0	1,917,184	4,438	31.00
40.00	04000	8,974	6,273,997	0	1,625,984	6,403	40.00
43.00	04300	59,301	1,125,629	0	566,932	416	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	897,316	45,906,784	0	4,948,321	27,073	50.00
52.00	05200	14,779	1,522,696	0	251,535	1,246	52.00
53.00	05300	97,227	7,039,666	0	279,328	85	53.00
53.01	03950	0	0	0	0	0	53.01
54.00	05400	272,458	15,486,742	0	3,188,804	7,091	54.00
54.01	05401	20,886	7,980,651	0	698,095	284	54.01
57.00	05700	100,813	30,154,049	0	877,600	567	57.00
58.00	05800	166,105	10,403,921	0	613,757	496	58.00
59.00	05900	1,471,855	29,527,424	0	2,034,194	5,447	59.00
60.00	06000	1,538,782	45,084,041	0	6,617,636	5,566	60.00
64.00	06400	144,605	5,664,578	0	166,246	0	64.00
65.00	06500	113,378	9,418,557	0	1,253,595	1,260	65.00
66.00	06600	36,330	13,612,411	0	2,697,935	8,910	66.00
67.00	06700	9,386	1,889,480	0	513,360	0	67.00
68.00	06800	180,925	1,580,489	0	510,727	1,750	68.00
69.00	06900	21,516	2,947,714	0	269,218	140	69.00
70.00	07000	20,692	3,357,646	0	458,826	1,630	70.00
71.00	07100	3,446,900	33,513,124	0	2,632,750	0	71.00
72.00	07200	0	7,195,787	0	5,991,352	0	72.00
73.00	07300	0	49,624,354	0	2,292,069	0	73.00
76.00	03550	940	1,234,089	0	345,746	2,852	76.00
76.97	07697	724,943	953,420	0	747,472	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,060,991	66,382,826	0	21,302,920	93,297	90.00
91.00	09100	232,273	23,143,513	0	4,939,388	14,029	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	22,897	989,961	0	892,075	3,665	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		11,750,846	449,997,371	-11,107,385	91,910,540	253,933	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	13,169	1,219	190.00
192.00	19200	0	127,737	0	252,460	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	289,894	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		1,418,305	5,495,191		11,107,385	5,080,761	202.00
203.00		0.120698	0.012208		0.120124	19.912683	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	323,395	136,416		140,188	1,397,192	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.027521	0.000303		0.001516	5.475920	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: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00590						5.02	
5.03	00591						5.03	
5.04	00580						5.04	
5.05	00592						5.05	
7.00	00700						7.00	
8.00	00800	396,356					8.00	
9.00	00900	0	2,083				9.00	
10.00	01000	0	14	55,369			10.00	
11.00	01100	0	33	0	410		11.00	
13.00	01300	0	10	0	10	789,443	13.00	
14.00	01400	0	24	0	1	0	14.00	
15.00	01500	0	26	0	11	0	15.00	
16.00	01600	0	64	0	17	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
17.01	01701	0	2	0	3	0	17.01	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	11	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	126,077	458	28,662	49	129,008	30.00	
31.00	03100	19,825	56	3,853	13	35,097	31.00	
40.00	04000	11,141	66	7,043	15	38,154	40.00	
43.00	04300	5,405	12	0	3	9,475	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	85,397	400	1,453	35	63,931	50.00	
52.00	05200	3,276	26	0	1	3,179	52.00	
53.00	05300	0	0	0	0	0	53.00	
53.01	03950	0	0	0	0	0	53.01	
54.00	05400	9,734	77	0	20	0	54.00	
54.01	05401	5,053	4	0	5	0	54.01	
57.00	05700	18,884	8	0	2	0	57.00	
58.00	05800	6,563	7	0	3	0	58.00	
59.00	05900	4,082	23	0	9	35,856	59.00	
60.00	06000	0	62	0	31	0	60.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	0	85	0	8	22,328	65.00	
66.00	06600	18,252	84	0	17	0	66.00	
67.00	06700	0	26	0	4	0	67.00	
68.00	06800	0	12	0	4	0	68.00	
69.00	06900	0	5	0	6	0	69.00	
70.00	07000	0	10	0	2	8,707	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	0	73.00	
76.00	03550	0	13	0	6	11,481	76.00	
76.97	07697	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	174	0	82	350,417	90.00	
91.00	09100	82,667	264	0	33	63,436	91.00	
92.00	09200						92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	20	0	9	18,374	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300						113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		396,356	2,065	41,011	410	789,443	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	18	0	0	0	190.00	
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	14,358	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)		332,573	1,541,399	675,851	1,465,062	2,820,815	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.839076	739.989918	12.206307	3,573.321951	3.573171	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	3,015	59,063	86,397	68,833	206,636	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.007607	28.354777	1.560386	167.885366	0.261749	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: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
		14.00	15.00	16.00	17.00	17.01		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00590						5.02	
5.03	00591						5.03	
5.04	00580						5.04	
5.05	00592						5.05	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300						13.00	
14.00	01400	7,697,243					14.00	
15.00	01500		3,540,006				15.00	
16.00	01600			124,707,000			16.00	
17.00	01700				10,957		17.00	
17.01	01701					10,957	17.01	
21.00	02100						21.00	
22.00	02200						22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000		4,708	11,682,302	6,634	6,634	30.00	
31.00	03100		745	13,132,163	1,381	1,381	31.00	
40.00	04000		104	6,273,997	2,350	2,350	40.00	
43.00	04300			1,125,629	592	592	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000		10,064	11,792,553			50.00	
52.00	05200		67	972,328			52.00	
53.00	05300			2,058,209			53.00	
53.01	03950						53.01	
54.00	05400		11,471	1,361,342			54.00	
54.01	05401		351	708,579			54.01	
57.00	05700		361	5,338,307			57.00	
58.00	05800		1,283	498,904			58.00	
59.00	05900		2,414	8,167,714			59.00	
60.00	06000		1,509	11,317,007			60.00	
64.00	06400		501,688	3,820,113			64.00	
65.00	06500		27,924	7,596,192			65.00	
66.00	06600		350	897,756			66.00	
67.00	06700			320,890			67.00	
68.00	06800			128,248			68.00	
69.00	06900			474,075			69.00	
70.00	07000			12,427			70.00	
71.00	07100	1,793,737		11,631,800			71.00	
72.00	07200	5,903,506		821,064			72.00	
73.00	07300		1,689,506	18,734,471			73.00	
76.00	03550			891,005			76.00	
76.97	07697						76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000		1,181,901	44,446			90.00	
91.00	09100		1,985	4,905,479			91.00	
92.00	09200						92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100		243				101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300						113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						10,957	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000						190.00	
192.00	19200						192.00	
194.00	07950						194.00	
194.01	07951		103,332				194.01	
194.02	07952						194.02	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)						202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)						203.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		14.00	15.00	16.00	17.00	17.01	
204.00	Cost to be allocated (per Wkst. B, Part II)	11,933	205,100	121,689	198	5,056	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001550	0.057938	0.000976	0.018071	0.461440	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: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES A (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS A (PATIENT DAYS)		
	21.00	22.00		
GENERAL SERVICE COST CENTERS				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01 00540	NONPATIENT TELEPHONES			5.01
5.02 00590	DATA PROCESSING			5.02
5.03 00591	PURCHASING RECEIVING AND STORES			5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05 00592	OTHER ADMIN & GENERAL			5.05
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
17.01 01701	UTILIZATION REVIEW			17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	8,607		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A		8,607	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	6,634	6,634	30.00
31.00 03100	INTENSIVE CARE UNIT	1,381	1,381	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	40.00
43.00 04300	NURSERY	592	592	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
53.01 03950	PAIN MANAGEMENT	0	0	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401	ULTRASOUND	0	0	54.01
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
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 PAT	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
91.00 09100	EMERGENCY	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8,607	8,607	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00 07950	MEALS ON WHEELS	0	0	194.00
194.01 07951	RETAIL PHARMACY	0	0	194.01
194.02 07952	IHAP	0	0	194.02
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,094,739	238,399	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	127.191704	27.698269	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-SALARY & FRINGES A (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS A (PATIENT DAYS)	
		21.00	22.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,681	6,826	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.195306	0.793075	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

	Description	Worksheet		Amount	
		CODE	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00
7.00	IV THERAPY & OP SERVICES		1 30.00	-69,937	7.00
8.00	IV THERAPY		1 64.00	1,028,081	8.00
9.00			1 0.00	0	9.00
10.00			1 0.00	0	10.00
11.00	IV THERAPY		1 50.00	-189,413	11.00
12.00	OUTPATIENT SERVICES		1 90.00	-9,558	12.00
13.00	IV THERAPY		1 91.00	-759,173	13.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,860,086	0	9,860,086	30.00
31.00	03100 INTENSIVE CARE UNIT		2,967,221	0	2,967,221	31.00
40.00	04000 SUBPROVIDER - I/PF		2,570,016	0	2,570,016	40.00
43.00	04300 NURSERY		759,886	0	759,886	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,993,934	0	6,993,934	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		372,887	0	372,887	52.00
53.00	05300 ANESTHESIOLOGY		376,729	0	376,729	53.00
53.01	03950 PAIN MANAGEMENT		0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,898,208	0	3,898,208	54.00
54.01	05401 ULTRASOUND		834,300	0	834,300	54.01
57.00	05700 CT SCAN		1,184,663	0	1,184,663	57.00
58.00	05800 MRI		734,665	0	734,665	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,815,951	0	2,815,951	59.00
60.00	06000 LABORATORY		8,022,787	9,633	8,032,420	60.00
64.00	06400 INTRAVENOUS THERAPY		1,654,532	0	1,654,532	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,848,013	0	1,848,013	65.00
66.00	06600 PHYSICAL THERAPY	0	3,365,001	0	3,365,001	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	618,250	0	618,250	67.00
68.00	06800 SPEECH PATHOLOGY	0	633,971	0	633,971	68.00
69.00	06900 ELECTROCARDIOLOGY		343,802	0	343,802	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		592,434	0	592,434	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		3,323,556	0	3,323,556	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,812,517	0	6,812,517	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,227,234	0	4,227,234	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		543,060	0	543,060	76.00
76.97	07697 CARDIAC REHABILITATION		837,261	0	837,261	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		28,150,701	20,800	28,171,501	90.00
91.00	09100 EMERGENCY		5,811,639	939,626	6,751,265	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,458,041		2,458,041	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		1,184,985		1,184,985	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		103,796,330	970,059	104,766,389	200.00
201.00	Less Observation Beds		2,458,041		2,458,041	201.00
202.00	Total (see instructions)		101,338,289	970,059	102,308,348	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		Charges			Hospital	PPS	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				Cost or Other Ratio
		6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,252,644		11,252,644			30.00
31.00	03100	INTENSIVE CARE UNIT	13,132,163		13,132,163			31.00
40.00	04000	SUBPROVIDER - IPF	6,273,997		6,273,997			40.00
43.00	04300	NURSERY	1,125,629		1,125,629			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,792,553	34,114,231	45,906,784	0.152351	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	972,328	550,368	1,522,696	0.244886	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,058,209	4,981,457	7,039,666	0.053515	0.000000	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,361,342	14,125,400	15,486,742	0.251713	0.000000	54.00
54.01	05401	ULTRASOUND	708,579	7,272,072	7,980,651	0.104540	0.000000	54.01
57.00	05700	CT SCAN	5,338,307	24,815,742	30,154,049	0.039287	0.000000	57.00
58.00	05800	MRI	498,904	9,905,017	10,403,921	0.070614	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,167,714	21,359,710	29,527,424	0.095367	0.000000	59.00
60.00	06000	LABORATORY	11,317,007	33,767,034	45,084,041	0.177952	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,820,113	1,844,465	5,664,578	0.292084	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	7,596,192	1,822,365	9,418,557	0.196210	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	897,756	12,714,655	13,612,411	0.247201	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	320,890	1,568,590	1,889,480	0.327206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	128,248	1,452,241	1,580,489	0.401123	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	474,075	2,473,639	2,947,714	0.116633	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,427	3,345,219	3,357,646	0.176443	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11,631,800	21,881,324	33,513,124	0.099172	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	821,064	6,374,723	7,195,787	0.946737	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,734,471	30,889,883	49,624,354	0.085185	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	891,005	343,084	1,234,089	0.440049	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	953,420	953,420	0.878166	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	44,446	39,785,250	39,829,696	0.706777	0.000000	90.00
91.00	09100	EMERGENCY	4,905,479	18,238,034	23,143,513	0.251113	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	429,658	3,169,357	3,599,015	0.682976	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	989,961	989,961			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	124,707,000	298,737,241	423,444,241			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	124,707,000	298,737,241	423,444,241			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.152351		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.244886		52.00
53.00	05300 ANESTHESIOLOGY	0.053515		53.00
53.01	03950 PAIN MANAGEMENT	0.000000		53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.251713		54.00
54.01	05401 ULTRASOUND	0.104540		54.01
57.00	05700 CT SCAN	0.039287		57.00
58.00	05800 MRI	0.070614		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.095367		59.00
60.00	06000 LABORATORY	0.178165		60.00
64.00	06400 INTRAVENOUS THERAPY	0.292084		64.00
65.00	06500 RESPIRATORY THERAPY	0.196210		65.00
66.00	06600 PHYSICAL THERAPY	0.247201		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327206		67.00
68.00	06800 SPEECH PATHOLOGY	0.401123		68.00
69.00	06900 ELECTROCARDIOLOGY	0.116633		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176443		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.099172		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.946737		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.085185		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.440049		76.00
76.97	07697 CARDIAC REHABILITATION	0.878166		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.707299		90.00
91.00	09100 EMERGENCY	0.291713		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.682976		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0012

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2018 4:09 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		9,860,086	0	9,860,086	30.00	
31.00	03100 INTENSIVE CARE UNIT		2,967,221	0	2,967,221	31.00	
40.00	04000 SUBPROVIDER - IPF		2,570,016	0	2,570,016	40.00	
43.00	04300 NURSERY		759,886	0	759,886	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		6,993,934	0	6,993,934	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		372,887	0	372,887	52.00	
53.00	05300 ANESTHESIOLOGY		376,729	0	376,729	53.00	
53.01	03950 PAIN MANAGEMENT		0	0	0	53.01	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,898,208	0	3,898,208	54.00	
54.01	05401 ULTRASOUND		834,300	0	834,300	54.01	
57.00	05700 CT SCAN		1,184,663	0	1,184,663	57.00	
58.00	05800 MRI		734,665	0	734,665	58.00	
59.00	05900 CARDIAC CATHETERIZATION		2,815,951	0	2,815,951	59.00	
60.00	06000 LABORATORY		8,022,787	9,633	8,032,420	60.00	
64.00	06400 INTRAVENOUS THERAPY		1,654,532	0	1,654,532	64.00	
65.00	06500 RESPIRATORY THERAPY	0	1,848,013	0	1,848,013	65.00	
66.00	06600 PHYSICAL THERAPY	0	3,365,001	0	3,365,001	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	618,250	0	618,250	67.00	
68.00	06800 SPEECH PATHOLOGY	0	633,971	0	633,971	68.00	
69.00	06900 ELECTROCARDIOLOGY		343,802	0	343,802	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		592,434	0	592,434	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		3,323,556	0	3,323,556	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,812,517	0	6,812,517	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		4,227,234	0	4,227,234	73.00	
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		543,060	0	543,060	76.00	
76.97	07697 CARDIAC REHABILITATION		837,261	0	837,261	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		28,150,701	20,800	28,171,501	90.00	
91.00	09100 EMERGENCY		5,811,639	939,626	6,751,265	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,458,041		2,458,041	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		1,184,985		1,184,985	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		103,796,330	970,059	104,766,389	200.00	
201.00	Less Observation Beds		2,458,041		2,458,041	201.00	
202.00	Total (see instructions)		101,338,289	970,059	102,308,348	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/18/2018 4:09 pm		
			Title XIX			Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00				9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	11,252,644		11,252,644				30.00
31.00	03100	INTENSIVE CARE UNIT	13,132,163		13,132,163				31.00
40.00	04000	SUBPROVIDER - IPF	6,273,997		6,273,997				40.00
43.00	04300	NURSERY	1,125,629		1,125,629				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,792,553	34,114,231	45,906,784	0.152351	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	972,328	550,368	1,522,696	0.244886	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	2,058,209	4,981,457	7,039,666	0.053515	0.000000		53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0.000000	0.000000		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,361,342	14,125,400	15,486,742	0.251713	0.000000		54.00
54.01	05401	ULTRASOUND	708,579	7,272,072	7,980,651	0.104540	0.000000		54.01
57.00	05700	CT SCAN	5,338,307	24,815,742	30,154,049	0.039287	0.000000		57.00
58.00	05800	MRI	498,904	9,905,017	10,403,921	0.070614	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,167,714	21,359,710	29,527,424	0.095367	0.000000		59.00
60.00	06000	LABORATORY	11,317,007	33,767,034	45,084,041	0.177952	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	3,820,113	1,844,465	5,664,578	0.292084	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	7,596,192	1,822,365	9,418,557	0.196210	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	897,756	12,714,655	13,612,411	0.247201	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	320,890	1,568,590	1,889,480	0.327206	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	128,248	1,452,241	1,580,489	0.401123	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	474,075	2,473,639	2,947,714	0.116633	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,427	3,345,219	3,357,646	0.176443	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11,631,800	21,881,324	33,513,124	0.099172	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	821,064	6,374,723	7,195,787	0.946737	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,734,471	30,889,883	49,624,354	0.085185	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	891,005	343,084	1,234,089	0.440049	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0	953,420	953,420	0.878166	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	44,446	39,785,250	39,829,696	0.706777	0.000000		90.00
91.00	09100	EMERGENCY	4,905,479	18,238,034	23,143,513	0.251113	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	429,658	3,169,357	3,599,015	0.682976	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	989,961	989,961				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	124,707,000	298,737,241	423,444,241				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	124,707,000	298,737,241	423,444,241				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/18/2018 4:09 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
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
53.01	03950	PAIN MANAGEMENT	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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 PAT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/18/2018 4:09 pm		
Title XVIII				Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	868,727	0	868,727	8,837	98.31	30.00	
31.00	INTENSIVE CARE UNIT	148,868	0	148,868	1,381	107.80	31.00	
40.00	SUBPROVIDER - IPF	138,482		138,482	2,350	58.93	40.00	
43.00	NURSERY	20,818		20,818	592	35.17	43.00	
200.00	Total (lines 30 through 199)	1,176,895		1,176,895	13,160		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,412	335,434					30.00
31.00	INTENSIVE CARE UNIT	658	70,932					31.00
40.00	SUBPROVIDER - IPF	739	43,549					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	4,809	449,915					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,094,375	45,906,784	0.023839	4,210,170	100,366	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,539	1,522,696	0.018086	0	0	52.00
53.00	05300	ANESTHESIOLOGY	34,133	7,039,666	0.004849	701,507	3,402	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0.000000	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	258,564	15,486,742	0.016696	805,740	13,453	54.00
54.01	05401	ULTRASOUND	69,725	7,980,651	0.008737	153,990	1,345	54.01
57.00	05700	CT SCAN	55,376	30,154,049	0.001836	2,619,348	4,809	57.00
58.00	05800	MRI	25,703	10,403,921	0.002471	248,361	614	58.00
59.00	05900	CARDIAC CATHETERIZATION	204,819	29,527,424	0.006937	3,910,855	27,130	59.00
60.00	06000	LABORATORY	393,009	45,084,041	0.008717	5,398,522	47,059	60.00
64.00	06400	INTRAVENOUS THERAPY	38,743	5,664,578	0.006840	31,371	215	64.00
65.00	06500	RESPIRATORY THERAPY	101,948	9,418,557	0.010824	3,489,791	37,773	65.00
66.00	06600	PHYSICAL THERAPY	192,885	13,612,411	0.014170	562,544	7,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,599	1,889,480	0.001905	194,315	370	67.00
68.00	06800	SPEECH PATHOLOGY	36,509	1,580,489	0.023100	101,220	2,338	68.00
69.00	06900	ELECTROCARDIOLOGY	8,435	2,947,714	0.002862	460,122	1,317	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,157	3,357,646	0.011364	7,430	84	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	123,141	33,513,124	0.003674	6,938,857	25,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,217	7,195,787	0.002949	698,404	2,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,656	49,624,354	0.002714	10,374,549	28,157	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	53,523	1,234,089	0.043370	259	11	76.00
76.97	07697	CARDIAC REHABILITATION	21,625	953,420	0.022682	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,332,828	39,829,696	0.058570	40,473	2,371	90.00
91.00	09100	EMERGENCY	307,571	23,143,513	0.013290	2,648,569	35,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	216,566	3,599,015	0.060174	426,776	25,681	92.00
200.00		Total (lines 50 through 199)	5,794,646	390,669,847		44,023,173	367,218	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	8,837	0.00	3,412	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,381	0.00	658	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,350	0.00	739	40.00
43.00	04300	NURSERY		0	592	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	13,160		4,809	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	45,906,784	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,522,696	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,039,666	0.000000	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,486,742	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	7,980,651	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	30,154,049	0.000000	57.00
58.00	05800	MRI	0	0	0	10,403,921	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	29,527,424	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	45,084,041	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,664,578	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,418,557	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,612,411	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,889,480	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,580,489	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,947,714	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,357,646	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	33,513,124	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,195,787	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,624,354	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,234,089	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	953,420	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	39,829,696	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,143,513	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	3,599,015	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	390,669,847		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		Title XVIII				Hospital		PPS
		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	4,210,170	0	7,749,641	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	701,507	0	944,247	0	53.00	
53.01	03950 PAIN MANAGEMENT	0.000000	0	0	0	0	53.01	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	805,740	0	4,723,850	0	54.00	
54.01	05401 ULTRASOUND	0.000000	153,990	0	717,215	0	54.01	
57.00	05700 CT SCAN	0.000000	2,619,348	0	7,679,846	0	57.00	
58.00	05800 MRI	0.000000	248,361	0	2,703,376	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	3,910,855	0	11,185,118	0	59.00	
60.00	06000 LABORATORY	0.000000	5,398,522	0	5,014,708	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	31,371	0	883,996	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	3,489,791	0	1,092,656	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	562,544	0	40,036	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	194,315	0	90,827	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	101,220	0	68,947	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	460,122	0	747,977	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	7,430	0	821,057	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	6,938,857	0	5,663,877	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	698,404	0	2,690,376	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	10,374,549	0	7,509,066	0	73.00	
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	259	0	53,576	0	76.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	534,812	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	40,473	0	3,357,736	0	90.00	
91.00	09100 EMERGENCY	0.000000	2,648,569	0	4,229,820	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	426,776	0	773,200	0	92.00	
200.00	Total (lines 50 through 199)		44,023,173	0	69,275,960	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/18/2018 4:09 pm
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		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.152351	7,749,641	0	3	1,180,666	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.244886	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.053515	944,247	0	0	50,531	53.00
53.01	03950 PAIN MANAGEMENT	0.000000	0	0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.251713	4,723,850	0	0	1,189,054	54.00
54.01	05401 ULTRASOUND	0.104540	717,215	0	0	74,978	54.01
57.00	05700 CT SCAN	0.039287	7,679,846	0	0	301,718	57.00
58.00	05800 MRI	0.070614	2,703,376	0	0	190,896	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.095367	11,185,118	0	0	1,066,691	59.00
60.00	06000 LABORATORY	0.177952	5,014,708	0	0	892,377	60.00
64.00	06400 INTRAVENOUS THERAPY	0.292084	883,996	0	6	258,201	64.00
65.00	06500 RESPIRATORY THERAPY	0.196210	1,092,656	0	0	214,390	65.00
66.00	06600 PHYSICAL THERAPY	0.247201	40,036	0	0	9,897	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327206	90,827	0	0	29,719	67.00
68.00	06800 SPEECH PATHOLOGY	0.401123	68,947	0	0	27,656	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116633	747,977	0	0	87,239	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176443	821,057	0	0	144,870	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.099172	5,663,877	0	0	561,698	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.946737	2,690,376	0	0	2,547,079	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.085185	7,509,066	4,750	99,872	639,660	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.440049	53,576	0	0	23,576	76.00
76.97	07697 CARDIAC REHABILITATION	0.878166	534,812	0	0	469,654	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.706777	3,357,736	0	258	2,373,171	90.00
91.00	09100 EMERGENCY	0.251113	4,229,820	0	74	1,062,163	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.682976	773,200	0	0	528,077	92.00
200.00	Subtotal (see instructions)		69,275,960	4,750	100,213	13,923,961	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		69,275,960	4,750	100,213	13,923,961	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/18/2018 4:09 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
53.01 03950 PAIN MANAGEMENT	0	0		53.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	2		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	405	8,508		73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	182		90.00
91.00 09100 EMERGENCY	0	19		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0		92.00
200.00 Subtotal (see instructions)	405	8,711		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	405	8,711		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0012 Component CCN: 14-S012		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 5/18/2018 4:09 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,094,375	45,906,784	0.023839	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,539	1,522,696	0.018086	0	0	52.00
53.00	05300	ANESTHESIOLOGY	34,133	7,039,666	0.004849	0	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0.000000	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	258,564	15,486,742	0.016696	6,275	105	54.00
54.01	05401	ULTRASOUND	69,725	7,980,651	0.008737	3,859	34	54.01
57.00	05700	CT SCAN	55,376	30,154,049	0.001836	15,659	29	57.00
58.00	05800	MRI	25,703	10,403,921	0.002471	5,764	14	58.00
59.00	05900	CARDIAC CATHETERIZATION	204,819	29,527,424	0.006937	7,739	54	59.00
60.00	06000	LABORATORY	393,009	45,084,041	0.008717	307,962	2,685	60.00
64.00	06400	INTRAVENOUS THERAPY	38,743	5,664,578	0.006840	5,522	38	64.00
65.00	06500	RESPIRATORY THERAPY	101,948	9,418,557	0.010824	72,441	784	65.00
66.00	06600	PHYSICAL THERAPY	192,885	13,612,411	0.014170	3,711	53	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,599	1,889,480	0.001905	350	1	67.00
68.00	06800	SPEECH PATHOLOGY	36,509	1,580,489	0.023100	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,435	2,947,714	0.002862	6,861	20	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,157	3,357,646	0.011364	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	123,141	33,513,124	0.003674	4,245	16	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,217	7,195,787	0.002949	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,656	49,624,354	0.002714	451,786	1,226	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	53,523	1,234,089	0.043370	38,182	1,656	76.00
76.97	07697	CARDIAC REHABILITATION	21,625	953,420	0.022682	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,332,828	39,829,696	0.058570	3,973	233	90.00
91.00	09100	EMERGENCY	307,571	23,143,513	0.013290	227,722	3,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	3,599,015	0.000000	2,882	0	92.00
200.00		Total (lines 50 through 199)	5,578,080	390,669,847		1,164,933	9,974	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/18/2018 4:09 pm
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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
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	03950 PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/18/2018 4:09 pm
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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	45,906,784	0.000000 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,522,696	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,039,666	0.000000 53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0.000000 53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,486,742	0.000000 54.00
54.01	05401	ULTRASOUND	0	0	0	7,980,651	0.000000 54.01
57.00	05700	CT SCAN	0	0	0	30,154,049	0.000000 57.00
58.00	05800	MRI	0	0	0	10,403,921	0.000000 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	29,527,424	0.000000 59.00
60.00	06000	LABORATORY	0	0	0	45,084,041	0.000000 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,664,578	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,418,557	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,612,411	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,889,480	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,580,489	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,947,714	0.000000 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,357,646	0.000000 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	33,513,124	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,195,787	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,624,354	0.000000 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,234,089	0.000000 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	953,420	0.000000 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	39,829,696	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	23,143,513	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	3,599,015	0.000000 92.00
200.00		Total (lines 50 through 199)	0	0	0	390,669,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
53.01	03950 PAIN MANAGEMENT	0.000000	0	0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	6,275	0	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	3,859	0	0	0	54.01
57.00	05700 CT SCAN	0.000000	15,659	0	0	0	57.00
58.00	05800 MRI	0.000000	5,764	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	7,739	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	307,962	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	5,522	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	72,441	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	3,711	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	350	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,861	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	4,245	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	451,786	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	38,182	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	3,973	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	227,722	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	2,882	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,164,933	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/18/2018 4:09 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,837	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,837	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)		6,634	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,412	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,860,086	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,860,086	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)		9,860,086	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)		1,115.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,807,007	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)		3,807,007	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
Title XVIII			Hospital		PPS			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	2,967,221	1,381	2,148.60	658	1,413,779		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)					6,671,174		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,891,960		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)					406,366		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					367,218		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					773,584		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,118,376		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)					2,203		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,115.77		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,458,041		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/18/2018 4:09 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	868,727	9,860,086	0.088105	2,458,041	216,566	90.00
91.00	Nursing School cost	0	9,860,086	0.000000	2,458,041	0	91.00
92.00	Allied health cost	0	9,860,086	0.000000	2,458,041	0	92.00
93.00	All other Medical Education	0	9,860,086	0.000000	2,458,041	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,350	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,350	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,350	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		739	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,570,016	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,570,016	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)		2,570,016	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)		1,093.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		808,185	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)		808,185	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012 Component CCN: 14-S012		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					203,184	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,011,369	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)					43,549	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					9,974	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					53,523	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					957,846	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012 Component CCN: 14-S012		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	138,482	2,570,016	0.053884	0	0	90.00
91.00	Nursing School cost	0	2,570,016	0.000000	0	0	91.00
92.00	Allied health cost	0	2,570,016	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,570,016	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/18/2018 4:09 pm	
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		7,958,078	30.00
31.00	03100	INTENSIVE CARE UNIT		2,862,958	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.152351	4,210,170	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.244886	0	52.00
53.00	05300	ANESTHESIOLOGY	0.053515	701,507	53.00
53.01	03950	PAIN MANAGEMENT	0.000000	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.251713	805,740	54.00
54.01	05401	ULTRASOUND	0.104540	153,990	54.01
57.00	05700	CT SCAN	0.039287	2,619,348	57.00
58.00	05800	MRI	0.070614	248,361	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.095367	3,910,855	59.00
60.00	06000	LABORATORY	0.178165	5,398,522	60.00
64.00	06400	INTRAVENOUS THERAPY	0.292084	31,371	64.00
65.00	06500	RESPIRATORY THERAPY	0.196210	3,489,791	65.00
66.00	06600	PHYSICAL THERAPY	0.247201	562,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327206	194,315	67.00
68.00	06800	SPEECH PATHOLOGY	0.401123	101,220	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116633	460,122	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.176443	7,430	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.099172	6,938,857	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.946737	698,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.085185	10,374,549	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.440049	259	76.00
76.97	07697	CARDIAC REHABILITATION	0.878166	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.707299	40,473	90.00
91.00	09100	EMERGENCY	0.291713	2,648,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.682976	426,776	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		44,023,173	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)		44,023,173	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		1,893,924	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.152351	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.244886	0	52.00
53.00	05300 ANESTHESIOLOGY	0.053515	0	53.00
53.01	03950 PAIN MANAGEMENT	0.000000	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.251713	6,275	54.00
54.01	05401 ULTRASOUND	0.104540	3,859	54.01
57.00	05700 CT SCAN	0.039287	15,659	57.00
58.00	05800 MRI	0.070614	5,764	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.095367	7,739	59.00
60.00	06000 LABORATORY	0.178165	307,962	60.00
64.00	06400 INTRAVENOUS THERAPY	0.292084	5,522	64.00
65.00	06500 RESPIRATORY THERAPY	0.196210	72,441	65.00
66.00	06600 PHYSICAL THERAPY	0.247201	3,711	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.327206	350	67.00
68.00	06800 SPEECH PATHOLOGY	0.401123	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.116633	6,861	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176443	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.099172	4,245	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.946737	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.085185	451,786	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.440049	38,182	76.00
76.97	07697 CARDIAC REHABILITATION	0.878166	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.707299	3,973	90.00
91.00	09100 EMERGENCY	0.291713	227,722	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.682976	2,882	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,164,933	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)		1,164,933	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,939,662	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,313,220	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		99,967	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		570,510	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		59.96	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		6.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		6.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.83	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.22	11.00
12.00	Current year allowable FTE (see instructions)		7.05	12.00
13.00	Total allowable FTE count for the prior year.		6.27	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		6.69	14.00
15.00	Sum of lines 12 through 14 divided by 3.		6.67	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		6.67	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.111241	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.095141	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.095141	21.00
22.00	IME payment adjustment (see instructions)		468,344	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		28,877	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-2.17	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		468,344	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		28,877	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.38	30.00
31.00	Percentage of Medicaid patient days (see instructions)		29.03	31.00
32.00	Sum of lines 30 and 31		31.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		277,587	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000069698	0.000099914	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		416,620	676,089	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		311,609	170,412	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		482,021		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		10,580,801		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			10,609,678	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			824,440	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			154,252	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			11,588,370	59.00
60.00	Primary payer payments			2,834	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			11,585,536	61.00
62.00	Deductibles billed to program beneficiaries			1,155,196	62.00
63.00	Coinurance billed to program beneficiaries			329	63.00
64.00	Allowable bad debts (see instructions)			140,510	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			91,332	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			106,077	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10,521,343	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			64,556	70.93
70.94	HRR adjustment amount (see instructions)			-4,998	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		114,937	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,465,964	71.00
71.01	Sequestration adjustment (see instructions)		209,319	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		10,200,927	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		55,718	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,939,662	6,939,662		6,939,662	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,313,220		2,313,220	2,313,220	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	99,967	74,975	24,992	99,967	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	570,510	570,510	0	570,510	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.095141	0.095141	0.095141		5.00
6.00	IME payment adjustment (see instructions)	22.00	468,344	351,258	117,086	468,344	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	28,877	28,877	0	28,877	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	468,344	351,258	117,086	468,344	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	28,877	28,877	0	28,877	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	277,587	208,190	69,397	277,587	11.00
11.01	Uncompensated care payments	36.00	482,021	311,609	170,412	482,021	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,580,801	7,885,694	2,695,107	10,580,801	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,609,678	7,914,571	2,695,107	10,609,678	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	824,440	616,636	207,804	824,440	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,531,207	2,902,911	11,434,118	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	750,258	561,152	189,106	750,258	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,559	5,654	1,905	7,559	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0888	0.0888	0.0888		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	66,623	49,830	16,793	66,623	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	824,440	616,636	207,804	824,440	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	64,556	48,284	16,272	64,556	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,998	-3,738	-1,260	-4,998	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		85,758	29,179	114,937	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,116	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,923,961	2.00
3.00	OPPS payments		12,672,221	3.00
4.00	Outlier payment (see instructions)		94,642	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)		9,116	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		104,963	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)		104,963	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		104,963	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		96,653	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		1.000000	17.00
18.00	Total customary charges (see instructions)		104,963	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		95,847	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)		9,116	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)		12,766,863	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,691,205	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)		10,084,774	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		166,598	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)		10,251,372	30.00
31.00	Primary payer payments		78	31.00
32.00	Subtotal (line 30 minus line 31)		10,251,294	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)		97,212	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		63,188	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		59,061	36.00
37.00	Subtotal (see instructions)		10,314,482	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)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,314,482	40.00
40.01	Sequestration adjustment (see instructions)		206,290	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		10,045,465	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		62,727	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: 14-0012		Period: From 01/01/2017 To 12/31/2017		Worksheet E-1 Part I Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,132,827		10,044,405	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	11/30/2017	68,100	11/30/2017	1,060	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)		68,100		1,060	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)		10,200,927		10,045,465	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		55,718		62,727	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		10,256,645		10,108,192	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: 14-0012
Component CCN: 14-S012

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

Worksheet E-1
Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		824,055		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)		824,055		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		10,520		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		834,575		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: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			678,196 1.00
2.00	Net IPF PPS Outlier Payments			299,620 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			6.438356 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			977,816 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			977,816 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			977,816 18.00
19.00	Deductibles			136,864 19.00
20.00	Subtotal (line 18 minus line 19)			840,952 20.00
21.00	Coinurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			840,952 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			16,392 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			10,655 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,844 25.00
26.00	Subtotal (sum of lines 22 and 24)			851,607 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			851,607 31.00
31.01	Sequestration adjustment (see instructions)			17,032 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			824,055 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			10,520 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			299,620 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/18/2018 4:09 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			6.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			6.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.83	6.00
7.00	Enter the lesser of line 5 or line 6			3.83	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	3.64	0.00	3.64	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	3.64	0.00	3.64	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		3.22		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	3.64	3.22		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.38	2.89		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	3.63	3.06		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.55	3.06		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	3.55	3.06		17.00
18.00	Per resident amount	100,758.33	100,758.33		18.00
19.00	Approved amount for resident costs	357,692	308,320	666,012	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			666,012	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,809	250		26.00
27.00	Total Inpatient Days (see instructions)	10,428	10,428		27.00
28.00	Ratio of inpatient days to total inpatient days	0.461162	0.023974		28.00
29.00	Program direct GME amount	307,139	15,967		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		2,256		30.00
31.00	Net Program direct GME amount			320,850	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		12,903,329	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		2,834	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		12,900,495	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		13,933,077	42.00
43.00	Primary payer payments (see instructions)		78	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		13,932,999	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		26,833,494	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.480761	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.519239	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		320,850	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		154,252	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		166,598	50.00

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

Provider CCN: 14-0012

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

Worksheet G
Date/Time Prepared:
5/18/2018 4:09 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	16,333,705	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	28,189,706	0	0	0	4.00
5.00	Other receivable	1,946,070	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,515,017	0	0	0	7.00
8.00	Prepaid expenses	1,000,178	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)	48,984,676	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,183,972	0	0	0	12.00
13.00	Land improvements	5,458,463	0	0	0	13.00
14.00	Accumulated depreciation	-3,258,952	0	0	0	14.00
15.00	Buildings	49,432,280	0	0	0	15.00
16.00	Accumulated depreciation	-30,002,705	0	0	0	16.00
17.00	Leasehold improvements	19,000	0	0	0	17.00
18.00	Accumulated depreciation	-19,000	0	0	0	18.00
19.00	Fixed equipment	32,287,220	0	0	0	19.00
20.00	Accumulated depreciation	-19,994,261	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	37,684,813	0	0	0	23.00
24.00	Accumulated depreciation	-31,950,835	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	499,719	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	42,339,714	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	32,638,769	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)	32,638,769	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	123,963,159	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,222,103	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,392,122	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	569,801	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	177,377	0	0	0	43.00
44.00	Other current liabilities	1,289,735	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,651,138	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,341,866	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,452,795	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,794,661	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	51,445,799	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	72,517,360				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)	72,517,360	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	123,963,159	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0012

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

Worksheet G-1

Date/Time Prepared:
5/18/2018 4:09 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		67,534,204		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,853,313			2.00
3.00	Total (sum of line 1 and line 2)		72,387,517		0	3.00
4.00	INCREASE IN RESTRICTED ASSETS	129,843		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		129,843		0	10.00
11.00	Subtotal (line 3 plus line 10)		72,517,360		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		72,517,360		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	INCREASE IN RESTRICTED ASSETS		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: 14-0012

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/18/2018 4:09 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,378,273		12,378,273	1.00
2.00	SUBPROVIDER - IPF	6,273,997		6,273,997	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)	18,652,270		18,652,270	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	13,132,163		13,132,163	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)	13,132,163		13,132,163	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,784,433		31,784,433	17.00
18.00	Ancillary services	87,542,984	236,554,639	324,097,623	18.00
19.00	Outpatient services	4,949,925	61,192,641	66,142,566	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		989,961	989,961	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS' PRIVATE OFFICES	0	41,883,221	41,883,221	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	124,277,342	340,620,462	464,897,804	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		132,997,903		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)		132,997,903		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0012

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

Worksheet G-3

Date/Time Prepared:
5/18/2018 4:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	464,897,804	1.00
2.00	Less contractual allowances and discounts on patients' accounts	330,723,583	2.00
3.00	Net patient revenues (line 1 minus line 2)	134,174,221	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	132,997,903	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,176,318	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	214,360	6.00
7.00	Income from investments	1,091,422	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	17,816	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	28,954	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	393,443	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	4,783	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	48,017	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,147	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	381,711	22.00
23.00	Governmental appropriations	165,009	23.00
24.00	MISCELLANEOUS REVENUE	410,748	24.00
24.01	RETAIL PHARMACY	981,487	24.01
24.02	GAIN ON DISPOSAL OF ASSETS	128,819	24.02
24.03	MEALS ON WHEELS	48,471	24.03
24.04	OTHER (SPECIFY)	0	24.04
25.00	Total other income (sum of lines 6-24)	3,918,187	25.00
26.00	Total (line 5 plus line 25)	5,094,505	26.00
27.00	WRITE OFF OF OLD PLEDGES RECEIVABLE	241,192	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	241,192	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,853,313	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0012

Period: From 01/01/2017

Worksheet H

HHA CCN: 14-7131

To 12/31/2017

Date/Time Prepared: 5/18/2018 4:09 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	217,235	16,884	0	3,888	58,522	296,529	5.00
HHA REIMBURSABLE SERVICES							
6.00	247,827	19,292	5,179	0	0	272,298	6.00
7.00	0	0	4,765	0	0	4,765	7.00
8.00	0	0	702	0	0	702	8.00
9.00	0	0	119	0	0	119	9.00
10.00	400	0	8	0	0	408	10.00
11.00	23,119	1,797	910	0	0	25,826	11.00
12.00	0	0	0	0	19,456	19,456	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	488,581	37,973	11,683	3,888	77,978	620,103	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	296,529	0	296,529			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	272,298	0	272,298			6.00
7.00	0	4,765	0	4,765			7.00
8.00	0	702	0	702			8.00
9.00	0	119	0	119			9.00
10.00	0	408	0	408			10.00
11.00	0	25,826	0	25,826			11.00
12.00	-9,689	9,767	0	9,767			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	-9,689	610,414	0	610,414			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part I Date/Time Prepared: 5/18/2018 4:09 pm
		HHA CCN: 14-7131	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	296,529	0	0	0	296,529	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	272,298	0	0	0	272,298	6.00	
7.00	Physical Therapy	4,765	0	0	0	4,765	7.00	
8.00	Occupational Therapy	702	0	0	0	702	8.00	
9.00	Speech Pathology	119	0	0	0	119	9.00	
10.00	Medical Social Services	408	0	0	0	408	10.00	
11.00	Home Health Aide	25,826	0	0	0	25,826	11.00	
12.00	Supplies (see instructions)	9,767	0	0	0	9,767	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Tel emedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	610,414	0	0	0	610,414	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					

GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	296,529					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	257,242	529,540				6.00
7.00	Physical Therapy	4,502	9,267				7.00
8.00	Occupational Therapy	663	1,365				8.00
9.00	Speech Pathology	112	231				9.00
10.00	Medical Social Services	385	793				10.00
11.00	Home Health Aide	24,398	50,224				11.00
12.00	Supplies (see instructions)	9,227	18,994				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		610,414				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0012

Period: From 01/01/2017

Worksheet H-1

HHA CCN: 14-7131

To 12/31/2017

Part II
Date/Time Prepared:
5/18/2018 4:09 pm

Home Health Agency I

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	0	0	0	100	-296,529	313,885
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	272,298
7.00	Physical Therapy	0	0	0	0	0	4,765
8.00	Occupational Therapy	0	0	0	0	0	702
9.00	Speech Pathology	0	0	0	0	0	119
10.00	Medical Social Services	0	0	0	0	0	408
11.00	Home Health Aide	0	0	0	0	0	25,826
12.00	Supplies (see instructions)	0	0	0	0	0	9,767
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	100	-296,529	313,885
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		296,529
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.944706

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part I Date/Time Prepared: 5/18/2018 4:09 pm
		HHA CCN: 14-7131	Home Health Agency I	PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				
1.00 Administrative and General	0	8,702	850	60,916	2,141	26,842	1.00
2.00 Skilled Nursing Care	529,540	20,959	0	69,494	5,711	53,685	2.00
3.00 Physical Therapy	9,267	0	0	0	0	0	3.00
4.00 Occupational Therapy	1,365	0	0	0	0	0	4.00
5.00 Speech Pathology	231	0	0	0	0	0	5.00
6.00 Medical Social Services	793	0	0	112	0	0	6.00
7.00 Home Health Aide	50,224	3,492	0	6,483	714	6,711	7.00
8.00 Supplies (see instructions)	18,994	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	610,414	33,153	850	137,005	8,566	87,238	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	5.03	5.04	5A.04	5.05	7.00	8.00	
1.00 Administrative and General	2,764	12,085	114,300	13,730	19,156	0	1.00
2.00 Skilled Nursing Care	0	0	679,389	81,611	46,138	0	2.00
3.00 Physical Therapy	0	0	9,267	1,113	0	0	3.00
4.00 Occupational Therapy	0	0	1,365	164	0	0	4.00
5.00 Speech Pathology	0	0	231	28	0	0	5.00
6.00 Medical Social Services	0	0	905	109	0	0	6.00
7.00 Home Health Aide	0	0	67,624	8,123	7,686	0	7.00
8.00 Supplies (see instructions)	0	0	18,994	2,282	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,764	12,085	892,075	107,160	72,980	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0012

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 14-7131

To 12/31/2017

Part I
Date/Time Prepared:
5/18/2018 4:09 pm

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,700	0	10,720	65,653	0	41	1.00
2.00	Skilled Nursing Care	9,620	0	21,440	0	0	99	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	1,480	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	17	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	14,800	0	32,160	65,653	0	157	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal		
	16.00	17.00	17.01	SERVICES-SALARIES & FRINGES A	SERVICES-OTHER PRGM COSTS A	22.00	24.00	
1.00	Administrative and General	0	0	0	0	0	227,300	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	838,297	2.00
3.00	Physical Therapy	0	0	0	0	0	10,380	3.00
4.00	Occupational Therapy	0	0	0	0	0	1,529	4.00
5.00	Speech Pathology	0	0	0	0	0	259	5.00
6.00	Medical Social Services	0	0	0	0	0	1,014	6.00
7.00	Home Health Aide	0	0	0	0	0	84,913	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	21,293	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,184,985	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part I Date/Time Prepared: 5/18/2018 4:09 pm
		HHA CCN: 14-7131	Home Health Agency I	PPS

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General	0	227,300				1.00
2.00 Skilled Nursing Care	0	838,297	198,963	1,037,260		2.00
3.00 Physical Therapy	0	10,380	2,464	12,844		3.00
4.00 Occupational Therapy	0	1,529	363	1,892		4.00
5.00 Speech Pathology	0	259	61	320		5.00
6.00 Medical Social Services	0	1,014	241	1,255		6.00
7.00 Home Health Aide	0	84,913	20,154	105,067		7.00
8.00 Supplies (see instructions)	0	21,293	5,054	26,347		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19) (2)	0	1,184,985	227,300	1,184,985		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.237343			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0012

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 14-7131

To 12/31/2017

Part II
Date/Time Prepared: 5/18/2018 4:09 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	962	823	217,235	3	4	22,897	1.00
2.00 Skilled Nursing Care	2,317	0	247,827	8	8	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	400	0	0	0	6.00
7.00 Home Health Aide	386	0	23,119	1	1	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	3,665	823	488,581	12	13	22,897	20.00
21.00 Total cost to be allocated	33,153	850	137,005	8,566	87,238	2,764	21.00
22.00 Unit cost multiplier	9.045839	1.032807	0.280414	713.833333	6,710.615385	0.120715	22.00
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
	5.04	5A.05	5.05	7.00	8.00	9.00	
1.00 Administrative and General	989,961	0	114,300	962	0	5	1.00
2.00 Skilled Nursing Care	0	0	679,389	2,317	0	13	2.00
3.00 Physical Therapy	0	0	9,267	0	0	0	3.00
4.00 Occupational Therapy	0	0	1,365	0	0	0	4.00
5.00 Speech Pathology	0	0	231	0	0	0	5.00
6.00 Medical Social Services	0	0	905	0	0	0	6.00
7.00 Home Health Aide	0	0	67,624	386	0	2	7.00
8.00 Supplies (see instructions)	0	0	18,994	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	989,961		892,075	3,665	0	20	20.00
21.00 Total cost to be allocated	12,085		107,160	72,980	0	14,800	21.00
22.00 Unit cost multiplier	0.012208		0.120124	19.912688	0.000000	740.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Prepared: 5/18/2018 4:09 pm
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UTILITIONS)	PHARMACY (COSTED REQ UTILITIONS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	3	18,374	0	63	0	1.00
2.00	Skilled Nursing Care	0	6	0	0	154	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	26	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	9	18,374	0	243	0	20.00
21.00	Total cost to be allocated	0	32,160	65,653	0	157	0	21.00
22.00	Unit cost multiplier	0.000000	3,573.333333	3.573147	0.000000	0.646091	0.000000	22.00
Cost Center Description		INTERNS & RESIDENTS						
		SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	SERVICES-SALARY & FRINGES (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS (PATIENT DAYS)			
		17.00	17.01	21.00	22.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part I Date/Time Prepared: 5/18/2018 4:09 pm		
				Title XVIII	Home Health Agency I	PPS		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,037,260		1,037,260	2,664	389.36	1.00
2.00	Physical Therapy	3.00	12,844	249,901	262,745	2,451	107.20	2.00
3.00	Occupational Therapy	4.00	1,892	52,856	54,748	361	151.66	3.00
4.00	Speech Pathology	5.00	320	8,935	9,255	61	151.72	4.00
5.00	Medical Social Services	6.00	1,255		1,255	4	313.75	5.00
6.00	Home Health Aide	7.00	105,067		105,067	468	224.50	6.00
7.00	Total (sum of lines 1-6)		1,158,638	311,692	1,470,330	6,009		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	1,203			8.00
9.00	Physical Therapy		99914	0	1,195			9.00
10.00	Occupational Therapy		99914	0	152			10.00
11.00	Speech Pathology		99914	0	22			11.00
12.00	Medical Social Services		99914	0	3			12.00
13.00	Home Health Aide		99914	0	250			13.00
14.00	Total (sum of lines 8-13)			0	2,825			14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	26,347	0	26,347	339,179	0.077679	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A			Cost of Services				
	6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,203		0	468,400		1.00
2.00	Physical Therapy	0	1,195		0	128,104		2.00
3.00	Occupational Therapy	0	152		0	23,052		3.00
4.00	Speech Pathology	0	22		0	3,338		4.00
5.00	Medical Social Services	0	3		0	941		5.00
6.00	Home Health Aide	0	250		0	56,125		6.00
7.00	Total (sum of lines 1-6)	0	2,825		0	679,960		7.00
Cost Center Description								
	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0012 HHA CCN: 14-7131		Period: From 01/01/2017 To 12/31/2017		Worksheet H-3 Part I Date/Time Prepared: 5/18/2018 4:09 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges				Cost of Services				
	Part A	Part B		Part A		Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00			
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	45,340	0	0	3,522	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description									
		Total Program Cost (sum of col.s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	468,400						1.00	
2.00	Physical Therapy	128,104						2.00	
3.00	Occupational Therapy	23,052						3.00	
4.00	Speech Pathology	3,338						4.00	
5.00	Medical Social Services	941						5.00	
6.00	Home Health Aide	56,125						6.00	
7.00	Total (sum of lines 1-6)	679,960						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0012

Period: From 01/01/2017

Worksheet H-3

HHA CCN: 14-7131

To 12/31/2017

Part II
Date/Time Prepared:
5/18/2018 4:09 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.247201	1,010,924	249,901	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.327206	161,538	52,856	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.401123	22,276	8,935	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.099172	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.085185	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2017 To 12/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	517,770
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	12,973
13.00	Total PPS Reimbursement - LUPA Episodes		0	7,612
14.00	Total PPS Reimbursement - PEP Episodes		0	536
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,329
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	541,220
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	541,220
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	541,220
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	541,220
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	541,220
31.01	Sequestration adjustment (see instructions)		0	10,824
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	530,396
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0012

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

Worksheet H-5

HHA CCN: 14-7131

Date/Time Prepared:
5/18/2018 4:09 pm

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		530,396	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		530,396	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		530,396	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0012	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/18/2018 4:09 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		750,258	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,559	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		22.13	3.00
4.00	Number of interns & residents (see instructions)		6.67	4.00
5.00	Indirect medical education percentage (see instructions)		8.88	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		66,623	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		824,440	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00