

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: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 4/2/2018 1:06 pm
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 4/2/2018 Time: 1:06 pm  
 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 SSM HEALTH GOOD SAMARITAN HOSPITAL ( 14-0046 ) 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	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	88,810	91,975	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	8,492	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	97,302	91,975	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 3/28/2018 12:51 pm		
1.00 Hospital and Hospital Health Care Complex Address:			2.00 PO Box:		3.00 State: IL Zip Code: 62864		4.00 County: JEFFERSON				
1.00 Street: 1 GOOD SAMARITAN WAY			2.00 City: MT. VERNON								
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		SSM HEALTH GOOD SAMARITAN HOSPITAL	140046	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		GOOD SAMARITAN REHABILITATION UNIT	14T046	99914	5	01/01/1990	N	P	P	4.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF										6.00
8.00	Swing Beds - NF										7.00
9.00	Hospital-Based SNF										8.00
10.00	Hospital-Based NF										9.00
11.00	Hospital-Based OLTC										10.00
12.00	Hospital-Based HHA										11.00
13.00	Separately Certified ASC										12.00
14.00	Hospital-Based Hospice		13.00								
15.00	Hospital-Based Health Clinic - RHC		14.00								
16.00	Hospital-Based Health Clinic - FQHC		15.00								
17.00	Hospital-Based (CMHC) I		16.00								
18.00	Renal Dialysis		17.00								
19.00	Other		18.00								
							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)					1				21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y		Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		5,782	910	0	2	69	251		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.		213	23	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 3/28/2018 12:51 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0				35.00
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0				36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00	
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		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)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			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).	0.00	0.00				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)	0.00	0.00				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)	0.00	0.00				61.06	
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count				
	1.00	2.00	3.00	4.00				
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		0.00	0.00			61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		0.00	0.00			61.20	
							1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00	
	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
	1.00	2.00	3.00					
<u>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.</u>								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00		0.000000	64.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			

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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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		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.				N		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	

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						1.00					
<b>Long Term Care Hospital PPS</b>											
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			
<b>TEFRA Providers</b>											
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 a "subclause (11)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.						N	87.00			
						V 1.00	XIX 2.00				
<b>Title V and XIX Services</b>											
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		
<b>Rural Providers</b>											
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)								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.								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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						N	N	N	N	109.00
						1.00					
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.							N		110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 3/28/2018 12:51 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	
<b>Miscellaneous Cost Reporting Information</b>					
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.	Y			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:	4,044,920	198		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
<b>Transplant Center Information</b>					
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
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		269020	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 3/28/2018 12:51 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: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301		
142.00	Street: 10101 WOODFIELD LANE	PO Box:				
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00
				1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00	166.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00
		Beginning		Ending		
		1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				08/02/2017	10/30/2017
				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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 3/28/2018 12:51 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/28/2018	Y	03/28/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 3/28/2018 12:51 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	ERIC		LAMOND	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162		ERIC.LAMOND@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 3/28/2018 12:51 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	MANAGER - GOVERNMENT 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: 14-0046

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/28/2018 12:51 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	108	39,420	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)		108	39,420	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	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)		124	45,260	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		134				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: 14-0046

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/28/2018 12:51 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	15,190	4,117	26,316			1.00
2.00 HMO and other (see instructions)	1,677	872				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	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)	15,190	4,117	26,316			7.00
8.00 INTENSIVE CARE UNIT	1,581	493	2,874			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		1,281	1,810			13.00
14.00 Total (see instructions)	16,771	5,891	31,000	0.00	969.86	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	1,301	243	1,834	0.00	14.00	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	983.86	27.00
28.00 Observation Bed Days		464	2,303			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			440			30.00
31.00 Employee discount days - IRF			24			31.00
32.00 Labor & delivery days (see instructions)	0	251	519			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: 14-0046

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/28/2018 12:51 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,896	1,652	7,544	1.00
2.00	HMO and other (see instructions)			361	68		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	3,896	1,652	7,544	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	120	0	171	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet S-3 Part II Date/Time Prepared: 3/28/2018 12:51 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		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	57,528,866	0	57,528,866	1,963,931.41	29.29	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		111,633	0	111,633	852.75	130.91	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,096,742	-210,586	1,886,156	46,753.01	40.34	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract Labor: Direct Patient Care		1,099,905	0	1,099,905	12,142.75	90.58	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		746,730	0	746,730	6,058.89	123.25	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		7,022,962	0	7,022,962	207,508.31	33.84	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		26,393,256	0	26,393,256			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		637,726	0	637,726			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		36,383	0	36,383			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		88,599	0	88,599			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,746,201	0	2,746,201			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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	203,135	210,586	413,721	15,589.34	26.54	26.00
27.00	Administrative & General	5.00	3,985,549	11,828	3,997,377	126,829.37	31.52	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
3/28/2018 12:51 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.)		450,508	0	450,508	3,900.78	115.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,019,140	0	1,019,140	47,862.10	21.29	30.00
31.00	Laundry & Linen Service	8.00	136,064	0	136,064	9,067.73	15.01	31.00
32.00	Housekeeping	9.00	1,428,778	0	1,428,778	102,800.92	13.90	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,539,702	-1,121,624	418,078	28,347.77	14.75	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,121,624	1,121,624	76,051.74	14.75	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	896,878	0	896,878	23,580.20	38.04	38.00
39.00	Central Services and Supply	14.00	355,692	-11,828	343,864	20,219.49	17.01	39.00
40.00	Pharmacy	15.00	1,973,499	0	1,973,499	49,790.93	39.64	40.00
41.00	Medical Records & Medical Records Library	16.00	622,193	0	622,193	32,666.59	19.05	41.00
42.00	Social Service	17.00	1,225,009	0	1,225,009	40,192.26	30.48	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
3/28/2018 12:51 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	57,979,374	0	57,979,374	1,967,832.19	29.46	1.00
2.00	Excluded area salaries (see instructions)	2,096,742	-210,586	1,886,156	46,753.01	40.34	2.00
3.00	Subtotal salaries (line 1 minus line 2)	55,882,632	210,586	56,093,218	1,921,079.18	29.20	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,869,597	0	8,869,597	225,709.95	39.30	4.00
5.00	Subtotal wage-related costs (see inst.)	29,175,840	0	29,175,840	0.00	52.01	5.00
6.00	Total (sum of lines 3 thru 5)	93,928,069	210,586	94,138,655	2,146,789.13	43.85	6.00
7.00	Total overhead cost (see instructions)	13,836,147	210,586	14,046,733	576,899.22	24.35	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 3/28/2018 12:51 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	1,557,696	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6,489,389	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	12,355,648	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	675,511	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	217,357	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	18,550	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	330,764	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	515,571	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	3,851,492	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	60,682	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	320,598	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	26,393,258	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 3/28/2018 12:51 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		1,099,905	26,393,258
2.00	Hospital		1,099,905	26,393,258
3.00	Subprovider - IPF			
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 3/28/2018 12:51 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.264864	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			16,908,827	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			4,014,062	5.00	
6.00	Medicaid charges			121,509,592	6.00	
7.00	Medicaid cost (line 1 times line 6)			32,183,517	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)			11,260,628	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>						
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>						
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)			11,260,628	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,925,601	2,652,139	11,577,740	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,364,070	2,652,139	5,016,209	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	368,179	206,165	574,344	22.00	
23.00	Cost of charity care (line 21 minus line 22)	1,995,891	2,445,974	4,441,865	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)			7,007,272	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			856,650	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,317,922	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			5,689,350	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,968,176	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			6,410,041	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,670,669	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet A	
Date/Time Prepared: 3/28/2018 12:51 pm							
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT		15,385,194		15,319,030	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,230,566		5,230,566	2.00
3.00	00300	OTHER CAP REL COSTS		0		0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	203,135	22,763,214	239,776	23,206,125	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,985,549	29,400,476	147,366	33,533,391	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	415	415	6.00
7.00	00700	OPERATION OF PLANT	1,019,140	4,424,778	0	5,443,918	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,064	563,387	0	699,451	8.00
9.00	00900	HOUSEKEEPING	1,428,778	811,478	0	2,240,256	9.00
10.00	01000	DIETARY	1,539,702	1,074,495	-1,883,122	731,075	10.00
11.00	01100	CAFETERIA	0	0	1,904,359	1,904,359	11.00
13.00	01300	NURSING ADMINISTRATION	896,878	104,032	0	1,000,910	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	355,692	356,196	-11,828	700,060	14.00
15.00	01500	PHARMACY	1,973,499	8,336,176	-5,413,916	4,895,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	622,193	213,021	0	835,214	16.00
17.00	01700	SOCIAL SERVICE	1,225,009	329,168	0	1,554,177	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,990,974	2,488,907	-3,325,201	17,154,680	30.00
31.00	03100	INTENSIVE CARE UNIT	2,389,047	1,439,949	-491,897	3,337,099	31.00
41.00	04100	SUBPROVIDER - IIRF	899,546	58,767	-5,687	952,626	41.00
43.00	04300	NURSERY	0	0	308,276	308,276	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,572,370	12,365,480	-9,085,717	6,852,133	50.00
51.00	05100	RECOVERY ROOM	475,482	42,561	-39,882	478,161	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,683,500	1,683,500	52.00
53.00	05300	ANESTHESIOLOGY	26,856	6,713,735	-299,926	6,440,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,684	223,641	-121,489	1,564,836	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	547,577	260,316	-167,115	640,778	55.00
56.00	05600	RADIOISOTOPE	239,312	447,773	-8,097	678,988	56.00
57.00	05700	CT SCAN	520,517	137,894	-66,422	591,989	57.00
58.00	05800	MRI	246,756	78,353	-62,567	262,542	58.00
59.00	05900	CARDIAC CATHETERIZATION	789,714	3,062,004	-2,907,811	943,907	59.00
60.00	06000	LABORATORY	2,182,117	3,641,901	-192,930	5,631,088	60.00
64.00	06400	INTRAVENOUS THERAPY	268,630	54,897	-52,939	270,588	64.00
65.00	06500	RESPIRATORY THERAPY	1,294,352	327,089	-195,325	1,426,116	65.00
66.00	06600	PHYSICAL THERAPY	1,275,873	26,985	-10,713	1,292,145	66.00
66.01	06601	CLINICAL NUTRITION	199,607	326	0	199,933	66.01
67.00	06700	OCCUPATIONAL THERAPY	813,876	132,589	-3,948	942,517	67.00
68.00	06800	SPEECH PATHOLOGY	298,655	7,045	-2,362	303,338	68.00
69.00	06900	ELECTROCARDIOLOGY	488,142	1,390,097	-18,993	1,859,246	69.00
69.01	06901	CARDIAC REHABILITATION	195,453	22,754	-1,611	216,596	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	66,158	12,152	0	78,310	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	9,915,705	9,915,705	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	6,101,619	6,101,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,343,567	161,822	5,284,676	6,790,065	73.00
74.00	07400	RENAL DIALYSIS	62,541	440,132	-8,244	494,429	74.00
76.00	03950	ACUTE DIALYSIS	153,574	225,292	-195,824	183,042	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	2,164,650	3,290,018	-197,710	5,256,958	90.00
91.00	09100	EMERGENCY	2,978,001	1,615,206	-417,450	4,175,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,331,670	127,659,866	183,991,536	330,802	184,322,338
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	81,834	12,410	94,244	0	94,244
192.00	19200	PHYSICIANS PRIVATE OFFICES	461,578	-262,828	198,750	-135,953	62,797
194.00	07950	NON-REIMBURSABLE	653,784	2,615,364	3,269,148	-194,849	3,074,299
200.00		TOTAL (SUM OF LINES 118 through 199)	57,528,866	130,024,812	187,553,678	0	187,553,678

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

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

Worksheet A  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-7,574,639	7,744,391	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,119,799	6,350,365	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,655,748	16,550,377	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,413,669	27,119,722	5.00
6.00	00600	MAINTENANCE & REPAIRS	-597,000	-596,585	6.00
7.00	00700	OPERATION OF PLANT	-61,261	5,382,657	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	699,451	8.00
9.00	00900	HOUSEKEEPING	-2,485	2,237,771	9.00
10.00	01000	DIETARY	-811,979	-80,904	10.00
11.00	01100	CAFETERIA	-11,148	1,893,211	11.00
13.00	01300	NURSING ADMINISTRATION	-5,545	995,365	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	700,060	14.00
15.00	01500	PHARMACY	-654,205	4,241,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,956	827,258	16.00
17.00	01700	SOCIAL SERVICE	-7,371	1,546,806	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-5,164,536	11,990,144	30.00
31.00	03100	INTENSIVE CARE UNIT	-797,594	2,539,505	31.00
41.00	04100	SUBPROVIDER - IRF	-19,811	932,815	41.00
43.00	04300	NURSERY	0	308,276	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-861,776	5,990,357	50.00
51.00	05100	RECOVERY ROOM	0	478,161	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,683,500	52.00
53.00	05300	ANESTHESIOLOGY	-6,187,209	253,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,040	1,562,796	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-43,992	596,786	55.00
56.00	05600	RADIOISOTOPE	0	678,988	56.00
57.00	05700	CT SCAN	0	591,989	57.00
58.00	05800	MRI	0	262,542	58.00
59.00	05900	CARDIAC CATHETERIZATION	-95	943,812	59.00
60.00	06000	LABORATORY	-8,827	5,622,261	60.00
64.00	06400	INTRAVENOUS THERAPY	0	270,588	64.00
65.00	06500	RESPIRATORY THERAPY	-21,628	1,404,488	65.00
66.00	06600	PHYSICAL THERAPY	0	1,292,145	66.00
66.01	06601	CLINICAL NUTRITION	0	199,933	66.01
67.00	06700	OCCUPATIONAL THERAPY	-30,100	912,417	67.00
68.00	06800	SPEECH PATHOLOGY	0	303,338	68.00
69.00	06900	ELECTROCARDIOLOGY	-957,128	902,118	69.00
69.01	06901	CARDIAC REHABILITATION	-27,751	188,845	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,128	76,182	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,915,705	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,101,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-139,812	6,650,253	73.00
74.00	07400	RENAL DIALYSIS	-47,176	447,253	74.00
76.00	03950	ACUTE DIALYSIS	0	183,042	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-2,022	5,254,936	90.00
91.00	09100	EMERGENCY	-963,249	3,212,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-36,960,081	147,362,257	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	94,244	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	62,797	192.00
194.00	07950	NON-REIMBURSABLE	0	3,074,299	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-36,960,081	150,593,597	200.00

RECLASSIFICATIONS

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - OBSTETRICS UNIT COST</b>					
1.00	NURSERY	43.00	302,097	6,179	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,649,755	33,745	2.00
	O		1,951,852	39,924	
<b>E - SHARED DIETARY COST</b>					
1.00	CAFETERIA	11.00	1,121,624	782,735	1.00
	O		1,121,624	782,735	
<b>F - MAILROOM COST</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	11,828	0	1.00
	O		11,828	0	
<b>G - CHILD CARE DIETARY</b>					
1.00	DIETARY	10.00	0	21,237	1.00
	O		0	21,237	
<b>H - EMPLOYEE CHILD CARE</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	210,586	29,190	1.00
	O		210,586	29,190	
<b>L - MEDICAL PLAZA EXPENSES</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	135,538	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	415	2.00
	O		0	135,953	
<b>M - CHILD CARE DEPRECIATION</b>					
1.00	NON-REIMBURSABLE	194.00	0	66,164	1.00
	O		0	66,164	
<b>N - C. SUPPLIES-CHARGEABLE IMPLANTABLES</b>					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	6,101,619	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	O		0	6,101,619	
<b>O - C SUPPLIES-CHARGEABLE MED SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	9,915,705	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	O		0	9,915,705	

Provider CCN: 14-0046

Period:  
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Worksheet A-6  
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		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
P - PHARM-DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	5,413,916	1.00
	0			0	5,413,916	
500.00	Grand Total: Increases			3,295,890	22,506,443	500.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6  
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - OBSTETRICS UNIT COST</b>							
1.00	ADULTS & PEDIATRICS	30.00	302,097	6,179	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,649,755	33,745	0		2.00
	O		1,951,852	39,924			
<b>E - SHARED DIETARY COST</b>							
1.00	DIETARY	10.00	1,121,624	782,735	0		1.00
	O		1,121,624	782,735			
<b>F - MAILROOM COST</b>							
1.00	CENTRAL SERVICE & SUPPLY	14.00	11,828	0	0		1.00
	O		11,828	0			
<b>G - CHILD CARE DIETARY</b>							
1.00	NON-REIMBURSABLE	194.00	0	21,237	0		1.00
	O		0	21,237			
<b>H - EMPLOYEE CHILD CARE</b>							
1.00	NON-REIMBURSABLE	194.00	210,586	29,190	0		1.00
	O		210,586	29,190			
<b>L - MEDICAL PLAZA EXPENSES</b>							
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	135,953	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	135,953			
<b>M - CHILD CARE DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,164	9		1.00
	O		0	66,164			
<b>N - C. SUPPLIES-CHARGEABLE IMPLANTABLES</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	12,235	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	203	0		2.00
3.00	OPERATING ROOM	50.00	0	4,733,622	0		3.00
4.00	RECOVERY ROOM	51.00	0	118	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	299	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	281	0		6.00
7.00	RADIOLOGY - THERAPEUTIC	55.00	0	35,051	0		7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	1,292,689	0		8.00
9.00	LABORATORY	60.00	0	721	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	79	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	498	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	24	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	461	0		13.00
14.00	RENAL DIALYSIS	74.00	0	118	0		14.00
15.00	ACUTE DIALYSIS	76.00	0	560	0		15.00
16.00	CLINIC	90.00	0	23,340	0		16.00
17.00	EMERGENCY	91.00	0	1,320	0		17.00
	O		0	6,101,619			
<b>O - C SUPPLIES-CHARGEABLE MED SUPPLIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	1,321,190	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	491,694	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	5,687	0		3.00
4.00	OPERATING ROOM	50.00	0	4,352,095	0		4.00
5.00	RECOVERY ROOM	51.00	0	39,764	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	299,627	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	121,208	0		7.00
8.00	RADIOLOGY - THERAPEUTIC	55.00	0	132,064	0		8.00
9.00	RADIOISOTOPE	56.00	0	8,097	0		9.00
10.00	CT SCAN	57.00	0	66,422	0		10.00
11.00	MRI	58.00	0	62,567	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	1,615,122	0		12.00
13.00	LABORATORY	60.00	0	192,209	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	52,939	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	195,325	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	10,713	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	3,869	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	1,864	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	18,969	0		19.00
20.00	CARDIAC REHABILITATION	69.01	0	1,611	0		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	128,779	0		21.00
22.00	RENAL DIALYSIS	74.00	0	8,126	0		22.00
23.00	ACUTE DIALYSIS	76.00	0	195,264	0		23.00
24.00	CLINIC	90.00	0	174,370	0		24.00
25.00	EMERGENCY	91.00	0	416,130	0		25.00
	O		0	9,915,705			
<b>P - PHARM-DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	5,413,916	0		1.00
	O		0	5,413,916			
500.00	Grand Total: Decreases		3,295,890	22,506,443			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	632,759	0	0	0	0	1.00
2.00	Land Improvements	6,605,970	30,107	0	30,107	0	2.00
3.00	Buildings and Fixtures	155,907,589	1,540,782	0	1,540,782	0	3.00
4.00	Building Improvements	20,089,763	14,015	0	14,015	0	4.00
5.00	Fixed Equipment	14,823,166	26,704	0	26,704	0	5.00
6.00	Movable Equipment	58,573,768	1,884,752	0	1,884,752	621,659	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	256,633,015	3,496,360	0	3,496,360	621,659	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	256,633,015	3,496,360	0	3,496,360	621,659	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	632,759	0				1.00
2.00	Land Improvements	6,636,077	0				2.00
3.00	Buildings and Fixtures	157,448,371	0				3.00
4.00	Building Improvements	20,103,778	0				4.00
5.00	Fixed Equipment	14,849,870	0				5.00
6.00	Movable Equipment	59,836,861	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	259,507,716	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	259,507,716	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:  
From 01/01/2017  
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Worksheet A-7  
Part II  
Date/Time Prepared:  
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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	8,693,624	0	6,691,570	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,230,566	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,924,190	0	6,691,570	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	15,385,194				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,230,566				2.00
3.00	Total (sum of lines 1-2)	0	20,615,760				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
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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	199,670,855	13,205,798	186,465,057	0.757059	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59,836,861	0	59,836,861	0.242941	0	2.00
3.00	Total (sum of lines 1-2)	259,507,716	13,205,798	246,301,918	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,837,343	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,350,365	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,187,708	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-1,092,952	0	0	0	7,744,391	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,350,365	2.00
3.00	Total (sum of lines 1-2)	-1,092,952	0	0	0	14,094,756	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:  
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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	-1,070,208	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-32,333	ADMINISTRATIVE & GENERAL		5.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-15,249,646				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC		54.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-17,730,518				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-811,660	DIETARY		10.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients	B	0	PHARMACY		15.00	0 17.00
18.00 Sale of medical records and abstracts	B	-7,956	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	B	-11,148	CAFETERIA		11.00	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 MISC REV	B	-2,296	HOUSEKEEPING		9.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:  
3/28/2018 12:51 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	
34.00	MISC REV	B	-136,889	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00	MISC REV	B	-6,120	RADIOLOGY - THERAPEUTIC	55.00	0 35.00
36.00	MISC REV	B	-61,192	OPERATION OF PLANT	7.00	0 36.00
36.50	MISC REV	B	-654,205	PHARMACY	15.00	0 36.50
37.00	MISC REV	B	-13,582	RESPIRATORY THERAPY	65.00	0 37.00
39.00	SOCIAL SERVICES REVENUE	B	-4,510	SOCIAL SERVICE	17.00	0 39.00
40.00	A&P REVENUE	B	-300	ADULTS & PEDIATRICS	30.00	0 40.00
40.05	ADVERTISING	A	-2,521	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 40.05
41.00	ADVERTISING	A	-29,916	ADMINISTRATIVE & GENERAL	5.00	0 41.00
41.01	MISC REV	B	-18,426	CARDIAC REHABILITATION	69.01	0 41.01
41.20	ADVERTISING	A	-109	DIETARY	10.00	0 41.20
41.40	ADVERTISING	A	-364	NURSING ADMINISTRATION	13.00	0 41.40
44.00	ADVERTISING	A	-109	SOCIAL SERVICE	17.00	0 44.00
45.01	ADVERTISING	A	-53	ADULTS & PEDIATRICS	30.00	0 45.01
45.02	ADVERTISING	A	-1,407	OPERATING ROOM	50.00	0 45.02
45.03	EMPLOYEE CHILD CARE	A	-319,668	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.03
45.04	REAL ESTATE TAXES	A	-96,369	ADMINISTRATIVE & GENERAL	5.00	0 45.04
45.05	ADVERTISING	A	-911	RADIOLOGY-DIAGNOSTIC	54.00	0 45.05
45.07	ADVERTISING	A	-28	OCCUPATIONAL THERAPY	67.00	0 45.07
45.08	LOBBYING DUES	A	-6,880	ADMINISTRATIVE & GENERAL	5.00	0 45.08
45.09	MGMT - CLAY	A	-262,004	ADMINISTRATIVE & GENERAL	5.00	0 45.09
45.10	GIFTS & ENTERTAINMENT	A	-95	CARDIAC CATHETERIZATION	59.00	0 45.10
45.11	GIFTS & ENTERTAINMENT	A	-83,723	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.11
45.12	GIFTS & ENTERTAINMENT	A	-98,401	ADMINISTRATIVE & GENERAL	5.00	0 45.12
45.13	GIFTS & ENTERTAINMENT	A	-61	CLINIC	90.00	0 45.13
45.15	GIFTS & ENTERTAINMENT	A	-69	OPERATION OF PLANT	7.00	0 45.15
45.16	GIFTS & ENTERTAINMENT	A	-189	HOUSEKEEPING	9.00	0 45.16
45.17	GIFTS & ENTERTAINMENT	A	-1,647	SUBPROVIDER - IRF	41.00	0 45.17
45.18	GIFTS & ENTERTAINMENT	A	-210	DIETARY	10.00	0 45.18
45.21	GIFTS & ENTERTAINMENT	A	-836	ADULTS & PEDIATRICS	30.00	0 45.21
45.22	GIFTS & ENTERTAINMENT	A	-2,089	INTENSIVE CARE UNIT	31.00	0 45.22
45.23	GIFTS & ENTERTAINMENT	A	-44	OPERATING ROOM	50.00	0 45.23
45.24	GIFTS & ENTERTAINMENT	A	-551	LABORATORY	60.00	0 45.24
45.25	GIFTS & ENTERTAINMENT	A	-5,181	NURSING ADMINISTRATION	13.00	0 45.25
45.26	ADVERTISING	A	-931	DRUGS CHARGED TO PATIENTS	73.00	0 45.26
45.27	GIFTS & ENTERTAINMENT	A	-126	ELECTROCARDIOLOGY	69.00	0 45.27
45.28	ADVERTISING	A	-1,961	CLINIC	90.00	0 45.28
45.29	ADVERTISING	A	-1,306	EMERGENCY	91.00	0 45.29
45.32	GIFTS & ENTERTAINMENT	A	-27	DRUGS CHARGED TO PATIENTS	73.00	0 45.32
45.33	GIFTS & ENTERTAINMENT	A	-2,199	EMERGENCY	91.00	0 45.33
45.34	MD RECRUITMENT	A	-54,068	ADULTS & PEDIATRICS	30.00	0 45.34
45.35	GIFTS & ENTERTAINMENT	A	-1,129	RADIOLOGY-DIAGNOSTIC	54.00	0 45.35
45.36	MD RECRUITMENT	A	-173,910	ADMINISTRATIVE & GENERAL	5.00	0 45.36
45.75	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.75
46.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-36,960,081			50.00

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS      Provider CCN: 14-0046      Period: From 01/01/2017 To 12/31/2017      Worksheet A-8-1  
 Date/Time Prepared: 3/28/2018 12:51 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	209,883	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,119,799	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	6,714,314
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	12,197,256	18,447,092
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	12,500,053	17,860,249
4.02	6.00	MAINTENANCE & REPAIRS	HOME OFFICE	0	597,000
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	-138,854	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			25,888,137	43,618,655

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 3/28/2018 12:51 pm
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	209,883	9		1.00
2.00	1,119,799	9		2.00
3.00	-6,714,314	11		3.00
4.00	-6,249,836	0		4.00
4.01	-5,360,196	0		4.01
4.02	-597,000	0		4.02
4.03	-138,854	0		4.03
5.00	-17,730,518			5.00

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

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

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

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

6.00	CORPORATE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0046

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

Worksheet A-8-2

Date/Time Prepared:  
3/28/2018 12:51 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	5.00	ADMINISTRATIVE & GENERAL	412,372	18,992	393,380	159,800	2,546	1.00
2.00	17.00	SOCIAL SERVICE	2,752	2,752	0	159,800	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	5,132,327	5,104,327	28,000	159,800	300	3.00
4.00	31.00	INTENSIVE CARE UNIT	795,505	795,505	0	159,800	0	4.00
5.00	41.00	SUBPROVIDER - IRF	65,489	0	65,489	159,800	616	5.00
6.00	50.00	OPERATING ROOM	860,325	860,325	0	159,800	0	6.00
7.00	53.00	ANESTHESIOLOGY	6,187,209	6,187,209	0	167,500	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	37,872	37,872	0	217,600	0	8.00
9.00	60.00	LABORATORY	108,876	8,250	100,626	208,000	1,006	9.00
10.00	65.00	RESPIRATORY THERAPY	8,046	8,046	0	159,800	0	10.00
11.00	67.00	OCCUPATIONAL THERAPY	30,072	30,072	0	159,800	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	1,112,961	909,987	202,974	159,800	2,030	12.00
13.00	69.01	CARDIAC REHABILITATION	18,544	0	18,544	159,800	120	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	9,350	0	9,350	159,800	94	14.00
15.00	74.00	RENAL DIALYSIS	62,541	22,541	40,000	159,800	200	15.00
16.00	91.00	EMERGENCY	959,744	959,744	0	159,800	0	16.00
200.00			15,803,985	14,945,622	858,363		6,912	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	5.00	ADMINISTRATIVE & GENERAL	195,601	9,780	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	23,048	1,152	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	47,325	2,366	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	100,600	5,030	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	155,959	7,798	0	0	0	12.00
13.00	69.01	CARDIAC REHABILITATION	9,219	461	0	0	0	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	7,222	361	0	0	0	14.00
15.00	74.00	RENAL DIALYSIS	15,365	768	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
200.00			554,339	27,716	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	195,601	197,779	216,771	1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	2,752	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	23,048	4,952	5,109,279	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	795,505	4.00
5.00	41.00	SUBPROVIDER - IRF	0	47,325	18,164	18,164	5.00
6.00	50.00	OPERATING ROOM	0	0	0	860,325	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	6,187,209	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	37,872	8.00
9.00	60.00	LABORATORY	0	100,600	26	8,276	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	8,046	10.00
11.00	67.00	OCCUPATIONAL THERAPY	0	0	0	30,072	11.00
12.00	69.00	ELECTROCARDIOLOGY	0	155,959	47,015	957,002	12.00
13.00	69.01	CARDIAC REHABILITATION	0	9,219	9,325	9,325	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,222	2,128	2,128	14.00
15.00	74.00	RENAL DIALYSIS	0	15,365	24,635	47,176	15.00
16.00	91.00	EMERGENCY	0	0	0	959,744	16.00
200.00			0	554,339	304,024	15,249,646	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,744,391	7,744,391			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,350,365		6,350,365		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,550,377	222,355	370	16,773,102	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	27,119,722	0	501,093	1,082,027	5.00
6.00 00600	MAINTENANCE & REPAIRS	-596,585	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	5,382,657	1,402,299	3,616,898	275,698	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	699,451	97,099	439	36,808	8.00
9.00 00900	HOUSEKEEPING	2,237,771	226,420	7,166	386,513	9.00
10.00 01000	DIETARY	-80,904	87,417	5,195	113,098	10.00
11.00 01100	CAFETERIA	1,893,211	228,338	0	303,422	11.00
13.00 01300	NURSING ADMINISTRATION	995,365	43,320	167,710	242,623	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	700,060	0	21,980	93,022	14.00
15.00 01500	PHARMACY	4,241,554	77,140	9,771	533,871	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	827,258	92,578	709	168,316	16.00
17.00 01700	SOCIAL SERVICE	1,546,806	77,186	0	332,134	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	11,990,144	1,280,010	46,314	5,591,019	30.00
31.00 03100	INTENSIVE CARE UNIT	2,539,505	399,929	52,832	646,961	31.00
41.00 04100	SUBPROVIDER - IRF	932,815	206,165	0	243,345	41.00
43.00 04300	NURSERY	308,276	24,457	0	81,723	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,990,357	717,602	370,084	946,169	50.00
51.00 05100	RECOVERY ROOM	478,161	0	5,851	128,627	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,683,500	220,597	0	446,292	52.00
53.00 05300	ANESTHESIOLOGY	253,456	5,846	12,995	7,265	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,562,796	511,324	252,183	395,490	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	596,786	0	469	146,954	55.00
56.00 05600	RADIOISOTOPE	678,988	0	41,106	64,739	56.00
57.00 05700	CT SCAN	591,989	88,079	62,747	140,762	57.00
58.00 05800	MRI	262,542	49,577	2,747	66,752	58.00
59.00 05900	CARDIAC CATHETERIZATION	943,812	150,376	51,536	178,836	59.00
60.00 06000	LABORATORY	5,622,261	202,899	69,916	592,538	60.00
64.00 06400	INTRAVENOUS THERAPY	270,588	30,920	115	72,670	64.00
65.00 06500	RESPIRATORY THERAPY	1,404,488	33,615	46,870	345,093	65.00
66.00 06600	PHYSICAL THERAPY	1,292,145	85,407	2,464	345,149	66.00
66.01 06601	CLINICAL NUTRITION	199,933	0	0	53,998	66.01
67.00 06700	OCCUPATIONAL THERAPY	912,417	78,625	516	228,305	67.00
68.00 06800	SPEECH PATHOLOGY	303,338	15,551	0	80,792	68.00
69.00 06900	ELECTROCARDIOLOGY	902,118	400,089	38,174	132,260	69.00
69.01 06901	CARDIAC REHABILITATION	188,845	0	7,487	52,874	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	76,182	0	1,516	17,897	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	9,915,705	0	0	61,501	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,101,619	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,650,253	0	2,922	363,462	73.00
74.00 07400	RENAL DIALYSIS	447,253	0	2,538	23,016	74.00
76.00 03950	ACUTE DIALYSIS	183,042	24,206	49,536	41,545	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	5,254,936	49,372	42,516	585,581	90.00
91.00 09100	EMERGENCY	3,212,508	355,878	34,209	805,609	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	147,362,257	7,484,676	5,528,974	16,454,756	145,962,805
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	94,244	32,496	474	22,138	149,352
192.00 19200	PHYSICIANS PRIVATE OFFICES	62,797	0	188,076	177,122	427,995
194.00 07950	NON-REIMBURSABLE	3,074,299	227,219	632,841	119,086	4,053,445
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	150,593,597	7,744,391	6,350,365	16,773,102	150,593,597

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B Part I Date/Time Prepared: 3/28/2018 12:51 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	28,702,842				5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	-596,585			6.00	
7.00	00700	OPERATION OF PLANT	2,502,103	0	13,179,655		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	195,386	0	209,116	1,238,299	8.00	
9.00	00900	HOUSEKEEPING	669,693	0	487,625	6,236	4,021,424	9.00
10.00	01000	DIETARY	29,246	0	188,263	2,370	60,650	10.00
11.00	01100	CAFETERIA	568,251	0	491,757	6,359	158,422	11.00
13.00	01300	NURSING ADMINISTRATION	339,553	0	93,296	0	30,056	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	190,996	0	0	0	0	14.00
15.00	01500	PHARMACY	1,139,406	0	166,132	0	53,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	255,156	0	199,378	0	64,231	16.00
17.00	01700	SOCIAL SERVICE	458,385	0	166,230	0	53,552	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	4,430,664	0	2,756,672	585,604	888,077	30.00
31.00	03100	INTENSIVE CARE UNIT	852,791	0	861,299	120,588	277,472	31.00
41.00	04100	SUBPROVIDER - IRF	323,924	0	444,002	62,352	143,038	41.00
43.00	04300	NURSERY	97,121	0	52,672	18,706	16,969	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,880,338	0	1,545,450	103,877	497,875	50.00
51.00	05100	RECOVERY ROOM	143,562	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	550,774	0	475,084	0	153,051	52.00
53.00	05300	ANESTHESIOLOGY	65,511	0	12,590	0	4,056	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	637,806	0	1,101,202	113,604	354,758	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	174,393	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	183,912	0	0	0	0	56.00
57.00	05700	CT SCAN	207,051	0	189,689	0	61,094	57.00
58.00	05800	MRI	89,426	0	106,771	24,940	34,397	58.00
59.00	05900	CARDIAC CATHETERIZATION	310,388	0	323,854	12,470	104,331	59.00
60.00	06000	LABORATORY	1,520,262	0	436,969	0	140,772	60.00
64.00	06400	INTRAVENOUS THERAPY	87,709	0	66,590	0	21,452	64.00
65.00	06500	RESPIRATORY THERAPY	428,845	0	72,394	0	23,322	65.00
66.00	06600	PHYSICAL THERAPY	404,263	0	183,935	0	59,256	66.00
66.01	06601	CLINICAL NUTRITION	59,504	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	285,854	0	169,329	0	54,550	67.00
68.00	06800	SPEECH PATHOLOGY	93,658	0	33,492	0	10,790	68.00
69.00	06900	ELECTROCARDIOLOGY	345,088	0	861,644	6,236	277,583	69.00
69.01	06901	CARDIAC REHABILITATION	58,397	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	22,401	0	0	3,117	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,337,989	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,429,811	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,644,230	0	0	40,279	0	73.00
74.00	07400	RENAL DIALYSIS	110,794	0	0	2,743	0	74.00
76.00	03950	ACUTE DIALYSIS	69,908	0	52,131	0	16,794	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1,390,158	0	106,328	0	34,254	90.00
91.00	09100	EMERGENCY	1,032,988	0	766,430	128,818	246,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,617,695	0	12,620,324	1,238,299	3,841,232	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	34,998	0	69,984	0	22,546	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	100,293	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE	949,856	0	489,347	0	157,646	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	-596,585	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,702,842	-596,585	13,179,655	1,238,299	4,021,424	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY		
	10.00	11.00	13.00	14.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
6.00 00600 MAINTENANCE & REPAIRS						6.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY	405,335					10.00	
11.00 01100 CAFETERIA	0	3,649,760				11.00	
13.00 01300 NURSING ADMINISTRATION	0	55,223	1,967,146			13.00	
14.00 01400 CENTRAL SERVICE & SUPPLY	0	50,203	26,140	1,082,401		14.00	
15.00 01500 PHARMACY	0	120,487	64,372	1,448	6,407,701	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	80,325	42,233	0	0	16.00	
17.00 01700 SOCIAL SERVICE	0	95,386	51,962	17	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	339,597	1,134,589	607,647	179,019	2,416	30.00	
31.00 03100 INTENSIVE CARE UNIT	18,358	200,812	107,968	57,706	0	31.00	
41.00 04100 SUBPROVIDER - IRF	16,902	70,284	37,652	854	0	41.00	
43.00 04300 NURSERY	0	25,102	12,782	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	22,960	286,157	153,233	486,518	6,728	50.00	
51.00 05100 RECOVERY ROOM	0	30,122	16,270	5,960	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	130,528	69,803	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	5,020	1,727	42,549	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	130,528	69,853	18,499	0	54.00	
55.00 05500 RADIOLOGY - THERAPEUTIC	0	45,183	24,017	8,882	0	55.00	
56.00 05600 RADIOISOTOPE	0	15,061	8,678	985	0	56.00	
57.00 05700 CT SCAN	0	45,183	23,788	9,646	0	57.00	
58.00 05800 MRI	0	20,081	9,830	9,323	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	40,162	21,638	73,870	0	59.00	
60.00 06000 LABORATORY	0	225,914	121,821	25,017	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	20,081	11,783	6,735	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	120,487	64,622	25,665	444	65.00	
66.00 06600 PHYSICAL THERAPY	0	100,406	54,640	1,638	0	66.00	
66.01 06601 CLINICAL NUTRITION	0	20,081	10,582	0	0	66.01	
67.00 06700 OCCUPATIONAL THERAPY	0	35,142	19,687	592	1,529	67.00	
68.00 06800 SPEECH PATHOLOGY	0	20,081	11,139	285	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	50,203	25,901	2,768	0	69.00	
69.01 06901 CARDIAC REHABILITATION	0	15,061	9,289	246	0	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	5,020	3,263	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	35,142	19,382	0	0	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	130,528	69,016	18,087	6,394,007	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	1,243	0	74.00	
76.00 03950 ACUTE DIALYSIS	0	10,041	5,867	23,542	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	30,122	16,100	26,656	2,421	90.00	
91.00 09100 EMERGENCY	7,477	251,015	134,137	54,585	156	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)						92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	405,294	3,649,760	1,926,822	1,082,335	6,407,701	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	8	0	8,348	0	0	190.00	
192.00 19200 PHYSICIANS PRIVATE OFFICES	11	0	10,528	0	0	192.00	
194.00 07950 NON-REIMBURSABLE	22	0	21,448	66	0	194.00	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	405,335	3,649,760	1,967,146	1,082,401	6,407,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,730,184				16.00
17.00	01700	SOCIAL SERVICE	0	2,781,658			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	107,713	2,336,593	32,276,078	0	32,276,078
31.00	03100	INTENSIVE CARE UNIT	19,927	278,166	6,434,314	0	6,434,314
41.00	04100	SUBPROVIDER - IRF	6,098	166,899	2,654,330	0	2,654,330
43.00	04300	NURSERY	6,038	0	643,846	0	643,846
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	252,375	0	13,259,723	0	13,259,723
51.00	05100	RECOVERY ROOM	31,298	0	839,851	0	839,851
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,946	0	3,769,575	0	3,769,575
53.00	05300	ANESTHESIOLOGY	53,543	0	464,558	0	464,558
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,574	0	5,215,617	0	5,215,617
55.00	05500	RADIOLOGY - THERAPEUTIC	12,245	0	1,008,929	0	1,008,929
56.00	05600	RADIOISOTOPE	27,725	0	1,021,194	0	1,021,194
57.00	05700	CT SCAN	142,092	0	1,562,120	0	1,562,120
58.00	05800	MRI	31,889	0	708,275	0	708,275
59.00	05900	CARDIAC CATHETERIZATION	100,377	0	2,311,650	0	2,311,650
60.00	06000	LABORATORY	254,242	0	9,212,611	0	9,212,611
64.00	06400	INTRAVENOUS THERAPY	7,689	0	596,332	0	596,332
65.00	06500	RESPIRATORY THERAPY	46,310	0	2,612,155	0	2,612,155
66.00	06600	PHYSICAL THERAPY	29,267	0	2,558,570	0	2,558,570
66.01	06601	CLINICAL NUTRITION	180	0	344,278	0	344,278
67.00	06700	OCCUPATIONAL THERAPY	11,864	0	1,798,410	0	1,798,410
68.00	06800	SPEECH PATHOLOGY	3,469	0	572,595	0	572,595
69.00	06900	ELECTROCARDIOLOGY	56,639	0	3,098,703	0	3,098,703
69.01	06901	CARDIAC REHABILITATION	2,957	0	335,156	0	335,156
70.00	07000	ELECTROENCEPHALOGRAPHY	773	0	130,169	0	130,169
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	32,802	0	12,402,521	0	12,402,521
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	69,401	0	7,600,831	0	7,600,831
73.00	07300	DRUGS CHARGED TO PATIENTS	171,081	0	15,483,865	0	15,483,865
74.00	07400	RENAL DIALYSIS	4,900	0	592,487	0	592,487
76.00	03950	ACUTE DIALYSIS	21,534	0	498,146	0	498,146
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	18,130	0	7,556,574	0	7,556,574
91.00	09100	EMERGENCY	98,426	0	7,129,146	0	7,129,146
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,728,504	2,781,658	144,692,609	0	144,692,609
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	285,236	0	285,236
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,680	0	540,507	0	540,507
194.00	07950	NON-REIMBURSABLE	0	0	5,671,830	0	5,671,830
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	-596,585	0	-596,585
202.00		TOTAL (sum lines 118 through 201)	1,730,184	2,781,658	150,593,597	0	150,593,597

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	222,355	370	222,725	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	85,789	0	501,093	586,882	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	48,690	1,402,299	3,616,898	5,067,887	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	97,099	439	97,538	8.00
9.00 00900	HOUSEKEEPING	44,850	226,420	7,166	278,436	9.00
10.00 01000	DIETARY	0	87,417	5,195	92,612	10.00
11.00 01100	CAFETERIA	0	228,338	0	228,338	11.00
13.00 01300	NURSING ADMINISTRATION	0	43,320	167,710	211,030	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	53,256	0	21,980	75,236	14.00
15.00 01500	PHARMACY	0	77,140	9,771	86,911	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	92,578	709	93,287	16.00
17.00 01700	SOCIAL SERVICE	0	77,186	0	77,186	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	60,619	1,280,010	46,314	1,386,943	30.00
31.00 03100	INTENSIVE CARE UNIT	13,855	399,929	52,832	466,616	31.00
41.00 04100	SUBPROVIDER - IRF	0	206,165	0	206,165	41.00
43.00 04300	NURSERY	0	24,457	0	24,457	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	369,578	717,602	370,084	1,457,264	50.00
51.00 05100	RECOVERY ROOM	0	0	5,851	5,851	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	220,597	0	220,597	52.00
53.00 05300	ANESTHESIOLOGY	986	5,846	12,995	19,827	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,839	511,324	252,183	785,346	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	469	469	55.00
56.00 05600	RADIOISOTOPE	0	0	41,106	41,106	56.00
57.00 05700	CT SCAN	0	88,079	62,747	150,826	57.00
58.00 05800	MRI	0	49,577	2,747	52,324	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	150,376	51,536	201,912	59.00
60.00 06000	LABORATORY	0	202,899	69,916	272,815	60.00
64.00 06400	INTRAVENOUS THERAPY	0	30,920	115	31,035	64.00
65.00 06500	RESPIRATORY THERAPY	25,066	33,615	46,870	105,551	65.00
66.00 06600	PHYSICAL THERAPY	557	85,407	2,464	88,428	66.00
66.01 06601	CLINICAL NUTRITION	0	0	0	0	66.01
67.00 06700	OCCUPATIONAL THERAPY	688	78,625	516	79,829	67.00
68.00 06800	SPEECH PATHOLOGY	0	15,551	0	15,551	68.00
69.00 06900	ELECTROCARDIOLOGY	0	400,089	38,174	438,263	69.00
69.01 06901	CARDIAC REHABILITATION	0	0	7,487	7,487	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	1,516	1,516	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	2,922	2,922	73.00
74.00 07400	RENAL DIALYSIS	0	0	2,538	2,538	74.00
76.00 03950	ACUTE DIALYSIS	0	24,206	49,536	73,742	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	291,172	49,372	42,516	383,060	90.00
91.00 09100	EMERGENCY	572	355,878	34,209	390,659	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,017,517	7,484,676	5,528,974	14,031,167	218,498
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	32,496	474	32,970	294
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	0	188,076	188,076	2,352
194.00 07950	NON-REIMBURSABLE	1,285,773	227,219	632,841	2,145,833	1,581
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	2,303,290	7,744,391	6,350,365	16,398,046	222,725

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 3/28/2018 12:51 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	601,249			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	52,416	0	5,123,964	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	4,093	0	81,300	183,420	8.00	
9.00	00900	HOUSEKEEPING	14,029	0	189,578	924	488,099	9.00
10.00	01000	DIETARY	613	0	73,193	351	7,361	10.00
11.00	01100	CAFETERIA	11,904	0	191,184	942	19,228	11.00
13.00	01300	NURSING ADMINISTRATION	7,113	0	36,271	0	3,648	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	4,001	0	0	0	0	14.00
15.00	01500	PHARMACY	23,869	0	64,589	0	6,496	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,345	0	77,514	0	7,796	16.00
17.00	01700	SOCIAL SERVICE	9,603	0	64,627	0	6,500	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	92,779	0	1,071,735	86,741	107,790	30.00
31.00	03100	INTENSIVE CARE UNIT	17,865	0	334,854	17,862	33,678	31.00
41.00	04100	SUBPROVIDER - IRF	6,786	0	172,618	9,236	17,361	41.00
43.00	04300	NURSERY	2,035	0	20,478	2,771	2,060	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	39,391	0	600,838	15,386	60,429	50.00
51.00	05100	RECOVERY ROOM	3,007	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,538	0	184,702	0	18,577	52.00
53.00	05300	ANESTHESIOLOGY	1,372	0	4,895	0	492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,361	0	428,124	16,827	43,059	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,653	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	3,853	0	0	0	0	56.00
57.00	05700	CT SCAN	4,337	0	73,747	0	7,415	57.00
58.00	05800	MRI	1,873	0	41,510	3,694	4,175	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,502	0	125,907	1,847	12,663	59.00
60.00	06000	LABORATORY	31,848	0	169,884	0	17,086	60.00
64.00	06400	INTRAVENOUS THERAPY	1,837	0	25,889	0	2,604	64.00
65.00	06500	RESPIRATORY THERAPY	8,984	0	28,145	0	2,831	65.00
66.00	06600	PHYSICAL THERAPY	8,469	0	71,510	0	7,192	66.00
66.01	06601	CLINICAL NUTRITION	1,247	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,988	0	65,831	0	6,621	67.00
68.00	06800	SPEECH PATHOLOGY	1,962	0	13,021	0	1,310	68.00
69.00	06900	ELECTROCARDIOLOGY	7,229	0	334,988	924	33,692	69.00
69.01	06901	CARDIAC REHABILITATION	1,223	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	469	0	0	462	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	48,978	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	29,953	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,445	0	0	5,966	0	73.00
74.00	07400	RENAL DIALYSIS	2,321	0	0	406	0	74.00
76.00	03950	ACUTE DIALYSIS	1,464	0	20,268	0	2,038	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	29,122	0	41,338	0	4,158	90.00
91.00	09100	EMERGENCY	21,640	0	297,971	19,081	29,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	578,517	0	4,906,509	183,420	466,229	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	733	0	27,208	0	2,736	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,101	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE	19,898	0	190,247	0	19,134	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	601,249	0	5,123,964	183,420	488,099	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

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

Worksheet B  
Part II  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	201,963				16.00
17.00	01700	SOCIAL SERVICE	0	181,319			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,570	152,308	3,347,270	0	3,347,270
31.00	03100	INTENSIVE CARE UNIT	2,326	18,132	951,156	0	951,156
41.00	04100	SUBPROVIDER - I R F	712	10,879	447,071	0	447,071
43.00	04300	NURSERY	705	0	58,468	0	58,468
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	29,453	0	2,321,044	0	2,321,044
51.00	05100	RECOVERY ROOM	3,653	0	20,694	0	20,694
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,662	0	471,813	0	471,813
53.00	05300	ANESTHESIOLOGY	6,249	0	37,343	0	37,343
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,886	0	1,327,215	0	1,327,215
55.00	05500	RADIOLOGY - THERAPEUTIC	1,429	0	17,157	0	17,157
56.00	05600	RADIOISOTOPE	3,236	0	52,200	0	52,200
57.00	05700	CT SCAN	16,583	0	264,465	0	264,465
58.00	05800	MRI	3,722	0	112,809	0	112,809
59.00	05900	CARDIAC CATHETERIZATION	11,714	0	377,047	0	377,047
60.00	06000	LABORATORY	29,713	0	576,111	0	576,111
64.00	06400	INTRAVENOUS THERAPY	897	0	67,902	0	67,902
65.00	06500	RESPIRATORY THERAPY	5,404	0	181,504	0	181,504
66.00	06600	PHYSICAL THERAPY	3,416	0	203,718	0	203,718
66.01	06601	CLINICAL NUTRITION	21	0	5,935	0	5,935
67.00	06700	OCCUPATIONAL THERAPY	1,385	0	169,856	0	169,856
68.00	06800	SPEECH PATHOLOGY	405	0	37,372	0	37,372
69.00	06900	ELECTROCARDIOLOGY	6,610	0	833,491	0	833,491
69.01	06901	CARDIAC REHABILITATION	345	0	12,924	0	12,924
70.00	07000	ELECTROENCEPHALOGRAPHY	90	0	3,847	0	3,847
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,828	0	60,652	0	60,652
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,099	0	38,052	0	38,052
73.00	07300	DRUGS CHARGED TO PATIENTS	19,966	0	307,775	0	307,775
74.00	07400	RENAL DIALYSIS	572	0	6,247	0	6,247
76.00	03950	ACUTE DIALYSIS	2,513	0	104,594	0	104,594
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	2,116	0	475,828	0	475,828
91.00	09100	EMERGENCY	11,487	0	838,387	0	838,387
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201,767	181,319	13,729,947	0	13,729,947
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	65,082	0	65,082
192.00	19200	PHYSICIANS PRIVATE OFFICES	196	0	194,164	0	194,164
194.00	07950	NON-REIMBURSABLE	0	0	2,379,630	0	2,379,630
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	29,223	0	29,223
202.00		TOTAL (sum lines 118 through 201)	201,963	181,319	16,398,046	0	16,398,046

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	339,129				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		14,098,761			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	822	62,003,265		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,112,501	3,999,805	-28,702,842	122,487,340
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	596,585	0
7.00 00700	OPERATION OF PLANT	61,407	8,030,056	1,019,140	0	10,677,552
8.00 00800	LAUNDRY & LINEN SERVICE	4,252	974	136,064	0	833,797
9.00 00900	HOUSEKEEPING	9,915	15,909	1,428,778	0	2,857,870
10.00 01000	DIETARY	3,828	11,534	418,078	0	124,806
11.00 01100	CAFETERIA	9,999	0	1,121,625	0	2,424,971
13.00 01300	NURSING ADMINISTRATION	1,897	372,342	896,878	0	1,449,018
14.00 01400	CENTRAL SERVICE & SUPPLY	0	48,799	343,864	0	815,062
15.00 01500	PHARMACY	3,378	21,692	1,973,499	0	4,862,336
16.00 01600	MEDICAL RECORDS & LIBRARY	4,054	1,574	622,193	0	1,088,861
17.00 01700	SOCIAL SERVICE	3,380	0	1,227,761	0	1,956,126
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	56,052	102,823	20,667,750	0	18,907,487
31.00 03100	INTENSIVE CARE UNIT	17,513	117,295	2,391,547	0	3,639,227
41.00 04100	SUBPROVIDER - IRF	9,028	0	899,546	0	1,382,325
43.00 04300	NURSERY	1,071	0	302,097	0	414,456
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	31,424	821,643	3,497,594	0	8,024,212
51.00 05100	RECOVERY ROOM	0	12,991	475,482	0	612,639
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,660	0	1,649,755	0	2,350,389
53.00 05300	ANESTHESIOLOGY	256	28,851	26,856	0	279,562
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,391	559,884	1,461,961	0	2,721,793
55.00 05500	RADIOLOGY - THERAPEUTIC	0	1,042	543,227	0	744,209
56.00 05600	RADIOISOTOPE	0	91,261	239,312	0	784,833
57.00 05700	CT SCAN	3,857	139,307	520,339	0	883,577
58.00 05800	MRI	2,171	6,099	246,756	0	381,618
59.00 05900	CARDIAC CATHETERIZATION	6,585	114,417	661,084	0	1,324,560
60.00 06000	LABORATORY	8,885	155,225	2,190,367	0	6,487,614
64.00 06400	INTRAVENOUS THERAPY	1,354	255	268,630	0	374,293
65.00 06500	RESPIRATORY THERAPY	1,472	104,058	1,275,666	0	1,830,066
66.00 06600	PHYSICAL THERAPY	3,740	5,470	1,275,873	0	1,725,165
66.01 06601	CLINICAL NUTRITION	0	0	199,607	0	253,931
67.00 06700	OCCUPATIONAL THERAPY	3,443	1,145	843,948	0	1,219,863
68.00 06800	SPEECH PATHOLOGY	681	0	298,655	0	399,681
69.00 06900	ELECTROCARDIOLOGY	17,520	84,752	488,910	0	1,472,641
69.01 06901	CARDIAC REHABILITATION	0	16,623	195,453	0	249,206
70.00 07000	ELECTROENCEPHALOGRAPHY	0	3,365	66,158	0	95,595
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	227,343	0	9,977,206
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	6,101,619
73.00 07300	DRUGS CHARGED TO PATIENTS	0	6,488	1,343,567	0	7,016,637
74.00 07400	RENAL DIALYSIS	0	5,634	85,082	0	472,807
76.00 03950	ACUTE DIALYSIS	1,060	109,978	153,574	0	298,329
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	2,162	94,393	2,164,650	0	5,932,405
91.00 09100	EMERGENCY	15,584	75,949	2,978,001	0	4,408,204
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	327,756	12,275,151	60,826,475	-28,106,257	117,856,548
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	1,423	1,052	81,834	0	149,352
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	417,557	654,745	0	427,995
194.00 07950	NON-REIMBURSABLE	9,950	1,405,001	440,211	0	4,053,445
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7,744,391	6,350,365	16,773,102		28,702,842
203.00	Unit cost multiplier (Wkst. B, Part I)	22.836121	0.450420	0.270520		0.234333
204.00	Cost to be allocated (per Wkst. B, Part II)			222,725		601,249
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003592		0.004909

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	267,985			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,252	1,012,579		8.00
9.00	00900	HOUSEKEEPING	0	9,915	5,099	253,817	9.00
10.00	01000	DIETARY	0	3,828	1,938	3,828	148,927
11.00	01100	CAFETERIA	0	9,999	5,200	9,999	0
13.00	01300	NURSING ADMINISTRATION	0	1,897	0	1,897	0
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	3,378	0	3,378	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,054	0	4,054	0
17.00	01700	SOCIAL SERVICE	0	3,380	0	3,380	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	56,052	478,859	56,052	124,774
31.00	03100	INTENSIVE CARE UNIT	0	17,513	98,607	17,513	6,745
41.00	04100	SUBPROVIDER - I RF	0	9,028	50,986	9,028	6,210
43.00	04300	NURSERY	0	1,071	15,296	1,071	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	31,424	84,942	31,424	8,436
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,660	0	9,660	0
53.00	05300	ANESTHESIOLOGY	0	256	0	256	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,391	92,896	22,391	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	3,857	0	3,856	0
58.00	05800	MRI	0	2,171	20,394	2,171	0
59.00	05900	CARDIAC CATHETERIZATION	0	6,585	10,197	6,585	0
60.00	06000	LABORATORY	0	8,885	0	8,885	0
64.00	06400	INTRAVENOUS THERAPY	0	1,354	0	1,354	0
65.00	06500	RESPIRATORY THERAPY	0	1,472	0	1,472	0
66.00	06600	PHYSICAL THERAPY	0	3,740	0	3,740	0
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	3,443	0	3,443	0
68.00	06800	SPEECH PATHOLOGY	0	681	0	681	0
69.00	06900	ELECTROCARDIOLOGY	0	17,520	5,099	17,520	0
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,549	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	32,937	0	0
74.00	07400	RENAL DIALYSIS	0	0	2,243	0	0
76.00	03950	ACUTE DIALYSIS	0	1,060	0	1,060	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	2,162	0	2,162	0
91.00	09100	EMERGENCY	0	15,584	105,337	15,584	2,747
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	256,612	1,012,579	242,444	148,912
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	1,423	0	1,423	3
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	4
194.00	07950	NON-REIMBURSABLE	0	9,950	0	9,950	8
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	-596,585	13,179,655	1,238,299	4,021,424	405,335
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	49.180570	1.222916	15.843793	2.721703
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,123,964	183,420	488,099	175,632
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	19.120339	0.181141	1.923035	0.983092

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		CAFETERIA (FTE SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (ADMINISTRATIVE CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	727					11.00
13.00	01300	11	1,521,561				13.00
14.00	01400	10	20,219	7,078,743			14.00
15.00	01500	24	49,791	9,468	5,425,512		15.00
16.00	01600	16	32,667	0	0	544,209,659	16.00
17.00	01700	19	40,192	110	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	226	470,005	1,170,753	2,046	33,882,685	30.00
31.00	03100	40	83,512	377,388	0	6,268,422	31.00
41.00	04100	14	29,123	5,588	0	1,918,079	41.00
43.00	04300	5	9,887	0	0	1,899,340	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	57	118,524	3,181,755	5,697	79,388,049	50.00
51.00	05100	6	12,585	38,978	0	9,845,379	51.00
52.00	05200	26	53,992	0	0	12,565,669	52.00
53.00	05300	1	1,336	278,266	0	16,842,588	53.00
54.00	05400	26	54,030	120,983	0	21,256,514	54.00
55.00	05500	9	18,577	58,088	0	3,851,817	55.00
56.00	05600	3	6,712	6,440	0	8,721,378	56.00
57.00	05700	9	18,400	63,084	0	44,697,008	57.00
58.00	05800	4	7,603	60,971	0	10,031,041	58.00
59.00	05900	8	16,737	483,101	0	31,575,154	59.00
60.00	06000	45	94,227	163,607	0	79,930,887	60.00
64.00	06400	4	9,114	44,044	0	2,418,750	64.00
65.00	06500	24	49,984	167,844	376	14,567,382	65.00
66.00	06600	20	42,263	10,713	0	9,206,353	66.00
66.01	06601	4	8,185	0	0	56,502	66.01
67.00	06700	7	15,228	3,869	1,295	3,732,119	67.00
68.00	06800	4	8,616	1,864	0	1,091,285	68.00
69.00	06900	10	20,034	18,101	0	17,816,739	69.00
69.01	06901	3	7,185	1,611	0	930,160	69.01
70.00	07000	1	2,524	0	0	243,080	70.00
71.00	07100	7	14,992	0	0	10,318,349	71.00
72.00	07200	0	0	0	0	21,831,227	72.00
73.00	07300	26	53,383	118,288	5,413,916	53,815,900	73.00
74.00	07400	0	0	8,126	0	1,541,437	74.00
76.00	03950	2	4,538	153,964	0	6,773,819	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	6	12,453	174,329	2,050	5,702,954	90.00
91.00	09100	50	103,753	356,979	132	30,961,256	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		727	1,490,371	7,078,312	5,425,512	543,681,322	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	6,457	0	0	0	190.00
192.00	19200	0	8,143	0	0	528,337	192.00
194.00	07950	0	16,590	431	0	0	194.00
200.00							200.00
201.00							201.00
202.00		3,649,760	1,967,146	1,082,401	6,407,701	1,730,184	202.00
203.00		5,020.302613	1.292847	0.152909	1.181032	0.003179	203.00
204.00		455,625	268,178	90,303	212,892	201,963	204.00
205.00		626.719395	0.176252	0.012757	0.039239	0.000371	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
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
66.01	06601	CLINICAL NUTRITION	66.01
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	06901	CARDIAC REHABILITATION	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	ACUTE DIALYSIS	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	NON-REIMBURSABLE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 3/28/2018 12:51 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		32,276,078	4,952	32,281,030	30.00
31.00	03100 INTENSIVE CARE UNIT		6,434,314	0	6,434,314	31.00
41.00	04100 SUBPROVIDER - I RF		2,654,330	18,164	2,672,494	41.00
43.00	04300 NURSERY		643,846	0	643,846	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		13,259,723	0	13,259,723	50.00
51.00	05100 RECOVERY ROOM		839,851	0	839,851	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,769,575	0	3,769,575	52.00
53.00	05300 ANESTHESIOLOGY		464,558	0	464,558	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,215,617	0	5,215,617	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		1,008,929	0	1,008,929	55.00
56.00	05600 RADIOISOTOPE		1,021,194	0	1,021,194	56.00
57.00	05700 CT SCAN		1,562,120	0	1,562,120	57.00
58.00	05800 MRI		708,275	0	708,275	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,311,650	0	2,311,650	59.00
60.00	06000 LABORATORY		9,212,611	26	9,212,637	60.00
64.00	06400 INTRAVENOUS THERAPY		596,332	0	596,332	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,612,155	0	2,612,155	65.00
66.00	06600 PHYSICAL THERAPY	0	2,558,570	0	2,558,570	66.00
66.01	06601 CLINICAL NUTRITION	0	344,278	0	344,278	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,798,410	0	1,798,410	67.00
68.00	06800 SPEECH PATHOLOGY	0	572,595	0	572,595	68.00
69.00	06900 ELECTROCARDIOLOGY		3,098,703	47,015	3,145,718	69.00
69.01	06901 CARDIAC REHABILITATION		335,156	9,325	344,481	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		130,169	2,128	132,297	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		12,402,521	0	12,402,521	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		7,600,831	0	7,600,831	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,483,865	0	15,483,865	73.00
74.00	07400 RENAL DIALYSIS		592,487	24,635	617,122	74.00
76.00	03950 ACUTE DIALYSIS		498,146	0	498,146	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		7,556,574	0	7,556,574	90.00
91.00	09100 EMERGENCY		7,129,146	0	7,129,146	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,597,692		2,597,692	92.00
200.00	Subtotal (see instructions)	0	147,290,301	106,245	147,396,546	200.00
201.00	Less Observation Beds		2,597,692		2,597,692	201.00
202.00	Total (see instructions)	0	144,692,609	106,245	144,798,854	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	33,882,686		33,882,686	30.00
31.00	03100	INTENSIVE CARE UNIT	6,268,422		6,268,422	31.00
41.00	04100	SUBPROVIDER - IRF	1,918,079		1,918,079	41.00
43.00	04300	NURSERY	1,899,340		1,899,340	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	41,258,166	38,129,883	79,388,049	50.00
51.00	05100	RECOVERY ROOM	4,764,141	5,081,239	9,845,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,434,811	3,130,858	12,565,669	52.00
53.00	05300	ANESTHESIOLOGY	9,268,001	7,574,587	16,842,588	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,680,617	14,938,868	21,619,485	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	340,878	3,510,939	3,851,817	55.00
56.00	05600	RADIOISOTOPE	1,630,510	7,090,868	8,721,378	56.00
57.00	05700	CT SCAN	12,678,744	32,018,264	44,697,008	57.00
58.00	05800	MRI	1,208,032	8,823,009	10,031,041	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,620,271	13,954,884	31,575,155	59.00
60.00	06000	LABORATORY	36,800,966	43,129,921	79,930,887	60.00
64.00	06400	INTRAVENOUS THERAPY	7,608	2,411,142	2,418,750	64.00
65.00	06500	RESPIRATORY THERAPY	12,646,089	1,921,293	14,567,382	65.00
66.00	06600	PHYSICAL THERAPY	6,251,966	2,954,386	9,206,352	66.00
66.01	06601	CLINICAL NUTRITION	234	56,268	56,502	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,871,505	860,614	3,732,119	67.00
68.00	06800	SPEECH PATHOLOGY	562,711	528,574	1,091,285	68.00
69.00	06900	ELECTROCARDIOLOGY	8,145,319	9,671,420	17,816,739	69.00
69.01	06901	CARDIAC REHABILITATION	188,160	742,000	930,160	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	203,340	39,740	243,080	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,688,570	3,629,779	10,318,349	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,288,564	7,542,662	21,831,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,765,764	22,050,136	53,815,900	73.00
74.00	07400	RENAL DIALYSIS	1,462,774	78,663	1,541,437	74.00
76.00	03950	ACUTE DIALYSIS	1,064,901	5,708,918	6,773,819	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	38,705	5,664,249	5,702,954	90.00
91.00	09100	EMERGENCY	7,284,601	23,676,655	30,961,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	240,510	2,005,802	2,246,312	92.00
200.00		Subtotal (see instructions)	279,364,985	266,925,621	546,290,606	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	279,364,985	266,925,621	546,290,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
41.00	04100 SUBPROVIDER - IRF		41.00
43.00	04300 NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.167024	50.00
51.00	05100 RECOVERY ROOM	0.085304	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.299990	52.00
53.00	05300 ANESTHESIOLOGY	0.027582	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.241246	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261936	55.00
56.00	05600 RADIOISOTOPE	0.117091	56.00
57.00	05700 CT SCAN	0.034949	57.00
58.00	05800 MRI	0.070608	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.073211	59.00
60.00	06000 LABORATORY	0.115258	60.00
64.00	06400 INTRAVENOUS THERAPY	0.246546	64.00
65.00	06500 RESPIRATORY THERAPY	0.179315	65.00
66.00	06600 PHYSICAL THERAPY	0.277914	66.00
66.01	06601 CLINICAL NUTRITION	6.093200	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.481874	67.00
68.00	06800 SPEECH PATHOLOGY	0.524698	68.00
69.00	06900 ELECTROCARDIOLOGY	0.176560	69.00
69.01	06901 CARDIAC REHABILITATION	0.370346	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.544253	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.201987	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.348163	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287719	73.00
74.00	07400 RENAL DIALYSIS	0.400355	74.00
76.00	03950 ACUTE DIALYSIS	0.073540	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	1.325028	90.00
91.00	09100 EMERGENCY	0.230260	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.156425	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 3/28/2018 12:51 pm
		Title XIX	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		32,276,078	4,952	32,281,030	30.00
31.00	03100 INTENSIVE CARE UNIT		6,434,314	0	6,434,314	31.00
41.00	04100 SUBPROVIDER - I RF		2,654,330	18,164	2,672,494	41.00
43.00	04300 NURSERY		643,846	0	643,846	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		13,259,723	0	13,259,723	50.00
51.00	05100 RECOVERY ROOM		839,851	0	839,851	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,769,575	0	3,769,575	52.00
53.00	05300 ANESTHESIOLOGY		464,558	0	464,558	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,215,617	0	5,215,617	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		1,008,929	0	1,008,929	55.00
56.00	05600 RADIOISOTOPE		1,021,194	0	1,021,194	56.00
57.00	05700 CT SCAN		1,562,120	0	1,562,120	57.00
58.00	05800 MRI		708,275	0	708,275	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,311,650	0	2,311,650	59.00
60.00	06000 LABORATORY		9,212,611	26	9,212,637	60.00
64.00	06400 INTRAVENOUS THERAPY		596,332	0	596,332	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,612,155	0	2,612,155	65.00
66.00	06600 PHYSICAL THERAPY	0	2,558,570	0	2,558,570	66.00
66.01	06601 CLINICAL NUTRITION	0	344,278	0	344,278	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,798,410	0	1,798,410	67.00
68.00	06800 SPEECH PATHOLOGY	0	572,595	0	572,595	68.00
69.00	06900 ELECTROCARDIOLOGY		3,098,703	47,015	3,145,718	69.00
69.01	06901 CARDIAC REHABILITATION		335,156	9,325	344,481	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		130,169	2,128	132,297	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		12,402,521	0	12,402,521	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		7,600,831	0	7,600,831	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,483,865	0	15,483,865	73.00
74.00	07400 RENAL DIALYSIS		592,487	24,635	617,122	74.00
76.00	03950 ACUTE DIALYSIS		498,146	0	498,146	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		7,556,574	0	7,556,574	90.00
91.00	09100 EMERGENCY		7,129,146	0	7,129,146	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,597,692		2,597,692	92.00
200.00	Subtotal (see instructions)	0	147,290,301	106,245	147,396,546	200.00
201.00	Less Observation Beds		2,597,692		2,597,692	201.00
202.00	Total (see instructions)	0	144,692,609	106,245	144,798,854	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,882,686		33,882,686		30.00
31.00	03100	INTENSIVE CARE UNIT	6,268,422		6,268,422		31.00
41.00	04100	SUBPROVIDER - IRF	1,918,079		1,918,079		41.00
43.00	04300	NURSERY	1,899,340		1,899,340		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	41,258,166	38,129,883	79,388,049	0.167024	50.00
51.00	05100	RECOVERY ROOM	4,764,141	5,081,239	9,845,380	0.085304	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,434,811	3,130,858	12,565,669	0.299990	52.00
53.00	05300	ANESTHESIOLOGY	9,268,001	7,574,587	16,842,588	0.027582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,680,617	14,938,868	21,619,485	0.241246	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	340,878	3,510,939	3,851,817	0.261936	55.00
56.00	05600	RADIOISOTOPE	1,630,510	7,090,868	8,721,378	0.117091	56.00
57.00	05700	CT SCAN	12,678,744	32,018,264	44,697,008	0.034949	57.00
58.00	05800	MRI	1,208,032	8,823,009	10,031,041	0.070608	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,620,271	13,954,884	31,575,155	0.073211	59.00
60.00	06000	LABORATORY	36,800,966	43,129,921	79,930,887	0.115257	60.00
64.00	06400	INTRAVENOUS THERAPY	7,608	2,411,142	2,418,750	0.246546	64.00
65.00	06500	RESPIRATORY THERAPY	12,646,089	1,921,293	14,567,382	0.179315	65.00
66.00	06600	PHYSICAL THERAPY	6,251,966	2,954,386	9,206,352	0.277914	66.00
66.01	06601	CLINICAL NUTRITION	234	56,268	56,502	6.093200	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,871,505	860,614	3,732,119	0.481874	67.00
68.00	06800	SPEECH PATHOLOGY	562,711	528,574	1,091,285	0.524698	68.00
69.00	06900	ELECTROCARDIOLOGY	8,145,319	9,671,420	17,816,739	0.173921	69.00
69.01	06901	CARDIAC REHABILITATION	188,160	742,000	930,160	0.360321	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	203,340	39,740	243,080	0.535499	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,688,570	3,629,779	10,318,349	1.201987	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,288,564	7,542,662	21,831,226	0.348163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,765,764	22,050,136	53,815,900	0.287719	73.00
74.00	07400	RENAL DIALYSIS	1,462,774	78,663	1,541,437	0.384373	74.00
76.00	03950	ACUTE DIALYSIS	1,064,901	5,708,918	6,773,819	0.073540	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	38,705	5,664,249	5,702,954	1.325028	90.00
91.00	09100	EMERGENCY	7,284,601	23,676,655	30,961,256	0.230260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	240,510	2,005,802	2,246,312	1.156425	92.00
200.00		Subtotal (see instructions)	279,364,985	266,925,621	546,290,606		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	279,364,985	266,925,621	546,290,606		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 3/28/2018 12:51 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
41.00	04100 SUBPROVIDER - IRF		41.00
43.00	04300 NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.167024	50.00
51.00	05100 RECOVERY ROOM	0.085304	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.299990	52.00
53.00	05300 ANESTHESIOLOGY	0.027582	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.241246	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261936	55.00
56.00	05600 RADIOISOTOPE	0.117091	56.00
57.00	05700 CT SCAN	0.034949	57.00
58.00	05800 MRI	0.070608	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.073211	59.00
60.00	06000 LABORATORY	0.115258	60.00
64.00	06400 INTRAVENOUS THERAPY	0.246546	64.00
65.00	06500 RESPIRATORY THERAPY	0.179315	65.00
66.00	06600 PHYSICAL THERAPY	0.277914	66.00
66.01	06601 CLINICAL NUTRITION	6.093200	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.481874	67.00
68.00	06800 SPEECH PATHOLOGY	0.524698	68.00
69.00	06900 ELECTROCARDIOLOGY	0.176560	69.00
69.01	06901 CARDIAC REHABILITATION	0.370346	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.544253	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.201987	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.348163	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287719	73.00
74.00	07400 RENAL DIALYSIS	0.400355	74.00
76.00	03950 ACUTE DIALYSIS	0.073540	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	1.325028	90.00
91.00	09100 EMERGENCY	0.230260	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.156425	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0046

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

Worksheet C Part II Date/Time Prepared: 3/28/2018 12:51 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	13,259,723	2,321,044	10,938,679	0	0	50.00
51.00	05100	RECOVERY ROOM	839,851	20,694	819,157	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,769,575	471,813	3,297,762	0	0	52.00
53.00	05300	ANESTHESIOLOGY	464,558	37,343	427,215	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,215,617	1,327,215	3,888,402	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,008,929	17,157	991,772	0	0	55.00
56.00	05600	RADIOISOTOPE	1,021,194	52,200	968,994	0	0	56.00
57.00	05700	CT SCAN	1,562,120	264,465	1,297,655	0	0	57.00
58.00	05800	MRI	708,275	112,809	595,466	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,311,650	377,047	1,934,603	0	0	59.00
60.00	06000	LABORATORY	9,212,611	576,111	8,636,500	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	596,332	67,902	528,430	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,612,155	181,504	2,430,651	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,558,570	203,718	2,354,852	0	0	66.00
66.01	06601	CLINICAL NUTRITION	344,278	5,935	338,343	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,798,410	169,856	1,628,554	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	572,595	37,372	535,223	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,098,703	833,491	2,265,212	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	335,156	12,924	322,232	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	130,169	3,847	126,322	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,402,521	60,652	12,341,869	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,600,831	38,052	7,562,779	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,483,865	307,775	15,176,090	0	0	73.00
74.00	07400	RENAL DIALYSIS	592,487	6,247	586,240	0	0	74.00
76.00	03950	ACUTE DIALYSIS	498,146	104,594	393,552	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	7,556,574	475,828	7,080,746	0	0	90.00
91.00	09100	EMERGENCY	7,129,146	838,387	6,290,759	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,597,692	269,360	2,328,332	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	105,281,733	9,195,342	96,086,391	0	0	200.00
201.00		Less Observation Beds	2,597,692	269,360	2,328,332	0	0	201.00
202.00		Total (line 200 minus line 201)	102,684,041	8,925,982	93,758,059	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part II Date/Time Prepared: 3/28/2018 12:51 pm
		Title XIX		Hospital
				PPS

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	13,259,723	79,388,049	0.167024	50.00
51.00	05100 RECOVERY ROOM	839,851	9,845,380	0.085304	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,769,575	12,565,669	0.299990	52.00
53.00	05300 ANESTHESIOLOGY	464,558	16,842,588	0.027582	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,215,617	21,619,485	0.241246	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	1,008,929	3,851,817	0.261936	55.00
56.00	05600 RADIOISOTOPE	1,021,194	8,721,378	0.117091	56.00
57.00	05700 CT SCAN	1,562,120	44,697,008	0.034949	57.00
58.00	05800 MRI	708,275	10,031,041	0.070608	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,311,650	31,575,155	0.073211	59.00
60.00	06000 LABORATORY	9,212,611	79,930,887	0.115257	60.00
64.00	06400 INTRAVENOUS THERAPY	596,332	2,418,750	0.246546	64.00
65.00	06500 RESPIRATORY THERAPY	2,612,155	14,567,382	0.179315	65.00
66.00	06600 PHYSICAL THERAPY	2,558,570	9,206,352	0.277914	66.00
66.01	06601 CLINICAL NUTRITION	344,278	56,502	6.093200	66.01
67.00	06700 OCCUPATIONAL THERAPY	1,798,410	3,732,119	0.481874	67.00
68.00	06800 SPEECH PATHOLOGY	572,595	1,091,285	0.524698	68.00
69.00	06900 ELECTROCARDIOLOGY	3,098,703	17,816,739	0.173921	69.00
69.01	06901 CARDIAC REHABILITATION	335,156	930,160	0.360321	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	130,169	243,080	0.535499	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	12,402,521	10,318,349	1.201987	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,600,831	21,831,226	0.348163	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,483,865	53,815,900	0.287719	73.00
74.00	07400 RENAL DIALYSIS	592,487	1,541,437	0.384373	74.00
76.00	03950 ACUTE DIALYSIS	498,146	6,773,819	0.073540	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	7,556,574	5,702,954	1.325028	90.00
91.00	09100 EMERGENCY	7,129,146	30,961,256	0.230260	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	2,597,692	2,246,312	1.156425	92.00
200.00	Subtotal (sum of lines 50 thru 199)	105,281,733	502,322,079		200.00
201.00	Less Observation Beds	2,597,692	0		201.00
202.00	Total (line 200 minus line 201)	102,684,041	502,322,079		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 3/28/2018 12:51 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	3,347,270	0	3,347,270	28,619	116.96	30.00	
31.00	INTENSIVE CARE UNIT	951,156	0	951,156	2,874	330.95	31.00	
41.00	SUBPROVIDER - IRF	447,071	0	447,071	1,834	243.77	41.00	
43.00	NURSERY	58,468		58,468	1,810	32.30	43.00	
200.00	Total (lines 30 through 199)	4,803,965		4,803,965	35,137		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	15,190	1,776,622					30.00
31.00	INTENSIVE CARE UNIT	1,581	523,232					31.00
41.00	SUBPROVIDER - IRF	1,301	317,145					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	18,072	2,616,999					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 3/28/2018 12:51 pm
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,321,044	79,388,049	0.029237	26,559,601	776,523	50.00
51.00	05100 RECOVERY ROOM	20,694	9,845,380	0.002102	2,616,881	5,501	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	471,813	12,565,669	0.037548	15,841	595	52.00
53.00	05300 ANESTHESIOLOGY	37,343	16,842,588	0.002217	4,072,245	9,028	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,327,215	21,619,485	0.061390	4,917,759	301,901	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	17,157	3,851,817	0.004454	557	2	55.00
56.00	05600 RADIOISOTOPE	52,200	8,721,378	0.005985	856,781	5,128	56.00
57.00	05700 CT SCAN	264,465	44,697,008	0.005917	7,252,226	42,911	57.00
58.00	05800 MRI	112,809	10,031,041	0.011246	610,400	6,865	58.00
59.00	05900 CARDIAC CATHETERIZATION	377,047	31,575,155	0.011941	7,335,858	87,597	59.00
60.00	06000 LABORATORY	576,111	79,930,887	0.007208	19,926,111	143,627	60.00
64.00	06400 INTRAVENOUS THERAPY	67,902	2,418,750	0.028073	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	181,504	14,567,382	0.012460	7,157,144	89,178	65.00
66.00	06600 PHYSICAL THERAPY	203,718	9,206,352	0.022128	3,481,519	77,039	66.00
66.01	06601 CLINICAL NUTRITION	5,935	56,502	0.105041	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	169,856	3,732,119	0.045512	1,094,949	49,833	67.00
68.00	06800 SPEECH PATHOLOGY	37,372	1,091,285	0.034246	219,140	7,505	68.00
69.00	06900 ELECTROCARDIOLOGY	833,491	17,816,739	0.046781	5,036,756	235,624	69.00
69.01	06901 CARDIAC REHABILITATION	12,924	930,160	0.013894	98,840	1,373	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	3,847	243,080	0.015826	136,307	2,157	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	60,652	10,318,349	0.005878	3,909,007	22,977	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,052	21,831,226	0.001743	7,924,854	13,813	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	307,775	53,815,900	0.005719	16,736,305	95,715	73.00
74.00	07400 RENAL DIALYSIS	6,247	1,541,437	0.004053	1,060,701	4,299	74.00
76.00	03950 ACUTE DIALYSIS	104,594	6,773,819	0.015441	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	475,828	5,702,954	0.083435	0	0	90.00
91.00	09100 EMERGENCY	838,387	30,961,256	0.027079	4,603,671	124,663	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	269,360	2,246,312	0.119912	151,139	18,123	92.00
200.00	Total (lines 50 through 199)	9,195,342	502,322,079		125,774,592	2,121,977	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 3/28/2018 12:51 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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	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	28,619	0.00	15,190 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,874	0.00	1,581 31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	1,834	0.00	1,301 41.00	
43.00	04300	NURSERY	0	0	1,810	0.00	0 43.00	
200.00		Total (lines 30 through 199)	0	0	35,137		18,072 200.00	
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
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description	Title XVIII					Allied Health Post-Stepdown Adjustments	Allied Health	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Hospital	PPS			
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
66.01 06601 CLINICAL NUTRITION	0	0	0	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHABILITATION	0	0	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	0	74.00
76.00 03950 ACUTE DIALYSIS	0	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00 09000 CLINIC	0	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	79,388,049	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,845,380	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,565,669	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,842,588	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,619,485	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	3,851,817	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,721,378	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	44,697,008	0.000000	57.00
58.00	05800	MRI	0	0	0	10,031,041	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31,575,155	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,930,887	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,418,750	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,567,382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,206,352	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	56,502	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,732,119	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,091,285	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,816,739	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	930,160	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	243,080	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,318,349	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	21,831,226	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,815,900	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,541,437	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	6,773,819	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,702,954	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,961,256	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	2,246,312	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	502,322,079		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	26,559,601	0	17,358,212	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	2,616,881	0	3,067,163	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	15,841	0	1,443	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	4,072,245	0	2,659,566	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,917,759	0	6,030,981	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	557	0	287,571	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	856,781	0	2,666,639	0	56.00
57.00	05700 CT SCAN	0.000000	7,252,226	0	10,746,040	0	57.00
58.00	05800 MRI	0.000000	610,400	0	3,098,541	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	7,335,858	0	6,176,773	0	59.00
60.00	06000 LABORATORY	0.000000	19,926,111	0	10,916,620	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	7,157,144	0	244,558	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	3,481,519	0	98,808	0	66.00
66.01	06601 CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,094,949	0	27,855	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	219,140	0	6,967	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	5,036,756	0	4,171,378	0	69.00
69.01	06901 CARDIAC REHABILITATION	0.000000	98,840	0	444,920	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	136,307	0	12,360	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	3,909,007	0	2,112,697	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	7,924,854	0	4,480,646	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	16,736,305	0	11,089,187	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,060,701	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0.000000	0	0	58,320	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	2,305,189	0	90.00
91.00	09100 EMERGENCY	0.000000	4,603,671	0	8,242,392	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	151,139	0	893,073	0	92.00
200.00	Total (lines 50 through 199)		125,774,592	0	97,197,899	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 3/28/2018 12:51 pm
		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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.167024	17,358,212	0	0	2,899,238	50.00
51.00	05100	RECOVERY ROOM	0.085304	3,067,163	0	0	261,641	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.299990	1,443	0	0	433	52.00
53.00	05300	ANESTHESIOLOGY	0.027582	2,659,566	0	0	73,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241246	6,030,981	0	0	1,454,950	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.261936	287,571	0	0	75,325	55.00
56.00	05600	RADIOISOTOPE	0.117091	2,666,639	0	0	312,239	56.00
57.00	05700	CT SCAN	0.034949	10,746,040	0	0	375,563	57.00
58.00	05800	MRI	0.070608	3,098,541	0	0	218,782	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.073211	6,176,773	0	0	452,208	59.00
60.00	06000	LABORATORY	0.115257	10,916,620	680	0	1,258,217	60.00
64.00	06400	INTRAVENOUS THERAPY	0.246546	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.179315	244,558	0	0	43,853	65.00
66.00	06600	PHYSICAL THERAPY	0.277914	98,808	0	0	27,460	66.00
66.01	06601	CLINICAL NUTRITION	6.093200	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.481874	27,855	0	0	13,423	67.00
68.00	06800	SPEECH PATHOLOGY	0.524698	6,967	0	0	3,656	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173921	4,171,378	0	0	725,490	69.00
69.01	06901	CARDIAC REHABILITATION	0.360321	444,920	0	0	160,314	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.535499	12,360	0	0	6,619	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.201987	2,112,697	0	0	2,539,434	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.348163	4,480,646	0	0	1,559,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287719	11,089,187	1,165	273,922	3,190,570	73.00
74.00	07400	RENAL DIALYSIS	0.384373	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0.073540	58,320	0	0	4,289	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1.325028	2,305,189	0	0	3,054,440	90.00
91.00	09100	EMERGENCY	0.230260	8,242,392	0	0	1,897,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.156425	893,073	0	0	1,032,772	92.00
200.00		Subtotal (see instructions)		97,197,899	1,845	273,922	21,642,160	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		97,197,899	1,845	273,922	21,642,160	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 3/28/2018 12:51 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	78	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
66.01 06601 CLINICAL NUTRITION	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHABILITATION	0	0		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	335	78,813		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 ACUTE DIALYSIS	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0		92.00
200.00 Subtotal (see instructions)	413	78,813		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	413	78,813		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 3/28/2018 12:51 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,321,044	79,388,049	0.029237	6,174	181	50.00
51.00	05100	RECOVERY ROOM	20,694	9,845,380	0.002102	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471,813	12,565,669	0.037548	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,343	16,842,588	0.002217	1,054	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,327,215	21,619,485	0.061390	11,541	709	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	17,157	3,851,817	0.004454	0	0	55.00
56.00	05600	RADIOISOTOPE	52,200	8,721,378	0.005985	0	0	56.00
57.00	05700	CT SCAN	264,465	44,697,008	0.005917	3,500	21	57.00
58.00	05800	MRI	112,809	10,031,041	0.011246	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	377,047	31,575,155	0.011941	0	0	59.00
60.00	06000	LABORATORY	576,111	79,930,887	0.007208	91,442	659	60.00
64.00	06400	INTRAVENOUS THERAPY	67,902	2,418,750	0.028073	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,504	14,567,382	0.012460	135,854	1,693	65.00
66.00	06600	PHYSICAL THERAPY	203,718	9,206,352	0.022128	879,254	19,456	66.00
66.01	06601	CLINICAL NUTRITION	5,935	56,502	0.105041	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	169,856	3,732,119	0.045512	862,555	39,257	67.00
68.00	06800	SPEECH PATHOLOGY	37,372	1,091,285	0.034246	144,623	4,953	68.00
69.00	06900	ELECTROCARDIOLOGY	833,491	17,816,739	0.046781	9,830	460	69.00
69.01	06901	CARDIAC REHABILITATION	12,924	930,160	0.013894	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,847	243,080	0.015826	1,145	18	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	60,652	10,318,349	0.005878	25,200	148	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,052	21,831,226	0.001743	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	307,775	53,815,900	0.005719	158,635	907	73.00
74.00	07400	RENAL DIALYSIS	6,247	1,541,437	0.004053	13,300	54	74.00
76.00	03950	ACUTE DIALYSIS	104,594	6,773,819	0.015441	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	475,828	5,702,954	0.083435	0	0	90.00
91.00	09100	EMERGENCY	838,387	30,961,256	0.027079	133,112	3,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	2,246,312	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,925,982	502,322,079		2,477,219	72,123	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 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
66.01	06601 CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	79,388,049	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,845,380	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,565,669	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,842,588	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,619,485	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	3,851,817	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,721,378	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	44,697,008	0.000000	57.00
58.00	05800	MRI	0	0	0	10,031,041	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31,575,155	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,930,887	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,418,750	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,567,382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,206,352	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	56,502	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,732,119	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,091,285	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,816,739	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	930,160	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	243,080	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,318,349	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	21,831,226	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,815,900	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,541,437	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	6,773,819	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,702,954	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,961,256	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,246,312	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	502,322,079		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	6,174	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,054	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,541	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	3,500	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	91,442	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	135,854	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	879,254	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	862,555	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	144,623	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,830	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,145	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	25,200	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	158,635	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	13,300	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	133,112	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,477,219	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 3/28/2018 12:51 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,347,270	0	3,347,270	28,619	116.96	30.00
31.00	INTENSIVE CARE UNIT	951,156	0	951,156	2,874	330.95	31.00
41.00	SUBPROVIDER - IRF	447,071	0	447,071	1,834	243.77	41.00
43.00	NURSERY	58,468		58,468	1,810	32.30	43.00
200.00	Total (lines 30 through 199)	4,803,965		4,803,965	35,137		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,117	481,524				
31.00	INTENSIVE CARE UNIT	493	163,158				
41.00	SUBPROVIDER - IRF	243	59,236				
43.00	NURSERY	1,281	41,376				
200.00	Total (lines 30 through 199)	6,134	745,294				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description		Title XIX			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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,321,044	79,388,049	0.029237	0	0 50.00
51.00	05100 RECOVERY ROOM	20,694	9,845,380	0.002102	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	471,813	12,565,669	0.037548	0	0 52.00
53.00	05300 ANESTHESIOLOGY	37,343	16,842,588	0.002217	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,327,215	21,619,485	0.061390	0	0 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	17,157	3,851,817	0.004454	0	0 55.00
56.00	05600 RADIOISOTOPE	52,200	8,721,378	0.005985	0	0 56.00
57.00	05700 CT SCAN	264,465	44,697,008	0.005917	0	0 57.00
58.00	05800 MRI	112,809	10,031,041	0.011246	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	377,047	31,575,155	0.011941	0	0 59.00
60.00	06000 LABORATORY	576,111	79,930,887	0.007208	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	67,902	2,418,750	0.028073	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	181,504	14,567,382	0.012460	0	0 65.00
66.00	06600 PHYSICAL THERAPY	203,718	9,206,352	0.022128	0	0 66.00
66.01	06601 CLINICAL NUTRITION	5,935	56,502	0.105041	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	169,856	3,732,119	0.045512	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	37,372	1,091,285	0.034246	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	833,491	17,816,739	0.046781	0	0 69.00
69.01	06901 CARDIAC REHABILITATION	12,924	930,160	0.013894	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	3,847	243,080	0.015826	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	60,652	10,318,349	0.005878	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,052	21,831,226	0.001743	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	307,775	53,815,900	0.005719	0	0 73.00
74.00	07400 RENAL DIALYSIS	6,247	1,541,437	0.004053	0	0 74.00
76.00	03950 ACUTE DIALYSIS	104,594	6,773,819	0.015441	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	475,828	5,702,954	0.083435	0	0 90.00
91.00	09100 EMERGENCY	838,387	30,961,256	0.027079	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	269,360	2,246,312	0.119912	0	0 92.00
200.00	Total (lines 50 through 199)	9,195,342	502,322,079		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 3/28/2018 12:51 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	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	28,619	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT			2,874	0.00	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,834	0.00	41.00
43.00	04300	NURSERY			1,810	0.00	43.00
200.00		Total (lines 30 through 199)			35,137		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
41.00	04100	SUBPROVIDER - IRF	0				41.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description	Title XIX				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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01 06601 CLINICAL NUTRITION	0	0	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHABILITATION	0	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03950 ACUTE DIALYSIS	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
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Cost Center Description		Title XIX			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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	79,388,049	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,845,380	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,565,669	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,842,588	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,619,485	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	3,851,817	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,721,378	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	44,697,008	0.000000	57.00
58.00	05800	MRI	0	0	0	10,031,041	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31,575,155	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,930,887	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,418,750	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,567,382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,206,352	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	56,502	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,732,119	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,091,285	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,816,739	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	930,160	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	243,080	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,318,349	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	21,831,226	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,815,900	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,541,437	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	6,773,819	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,702,954	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,961,256	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	2,246,312	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	502,322,079		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

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

Worksheet D  
Part IV  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		Title XIX			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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 3/28/2018 12:51 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,321,044	79,388,049	0.029237	0	0	50.00
51.00	05100 RECOVERY ROOM	20,694	9,845,380	0.002102	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	471,813	12,565,669	0.037548	0	0	52.00
53.00	05300 ANESTHESIOLOGY	37,343	16,842,588	0.002217	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,327,215	21,619,485	0.061390	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	17,157	3,851,817	0.004454	0	0	55.00
56.00	05600 RADIOISOTOPE	52,200	8,721,378	0.005985	0	0	56.00
57.00	05700 CT SCAN	264,465	44,697,008	0.005917	0	0	57.00
58.00	05800 MRI	112,809	10,031,041	0.011246	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	377,047	31,575,155	0.011941	0	0	59.00
60.00	06000 LABORATORY	576,111	79,930,887	0.007208	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	67,902	2,418,750	0.028073	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	181,504	14,567,382	0.012460	0	0	65.00
66.00	06600 PHYSICAL THERAPY	203,718	9,206,352	0.022128	0	0	66.00
66.01	06601 CLINICAL NUTRITION	5,935	56,502	0.105041	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	169,856	3,732,119	0.045512	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	37,372	1,091,285	0.034246	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	833,491	17,816,739	0.046781	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	12,924	930,160	0.013894	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	3,847	243,080	0.015826	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	60,652	10,318,349	0.005878	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,052	21,831,226	0.001743	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	307,775	53,815,900	0.005719	0	0	73.00
74.00	07400 RENAL DIALYSIS	6,247	1,541,437	0.004053	0	0	74.00
76.00	03950 ACUTE DIALYSIS	104,594	6,773,819	0.015441	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	475,828	5,702,954	0.083435	0	0	90.00
91.00	09100 EMERGENCY	838,387	30,961,256	0.027079	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	2,246,312	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	8,925,982	502,322,079		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 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
66.01	06601 CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm
	Title XIX	Subprovider - IRF	PPS

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
			4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	79,388,049	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,845,380	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,565,669	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,842,588	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,619,485	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	3,851,817	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,721,378	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	44,697,008	0.000000	57.00
58.00	05800	MRI	0	0	0	10,031,041	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31,575,155	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,930,887	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,418,750	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,567,382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,206,352	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	56,502	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,732,119	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,091,285	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,816,739	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	930,160	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	243,080	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,318,349	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	21,831,226	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,815,900	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,541,437	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	6,773,819	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,702,954	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,961,256	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,246,312	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	502,322,079		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part IV Date/Time Prepared: 3/28/2018 12:51 pm	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,619	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,619	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.		25,316	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,000	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)		15,190	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
<b>SWING BED ADJUSTMENT</b>				
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)		32,281,030	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)		32,281,030	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		33,928,960	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		33,928,960	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.951430	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)		33,928.96	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)		32,281,030	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,127.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,133,712	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		17,133,712	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	6,434,314	2,874	2,238.80	1,581	3,539,543	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)					27,019,702	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					47,692,957	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,299,854	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,121,977	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,421,831	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					43,271,126	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)					2,303	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,127.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,597,692	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 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	3,347,270	32,281,030	0.103692	2,597,692	269,360	90.00
91.00	Nursing School cost	0	32,281,030	0.000000	2,597,692	0	91.00
92.00	Allied health cost	0	32,281,030	0.000000	2,597,692	0	92.00
93.00	All other Medical Education	0	32,281,030	0.000000	2,597,692	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,834	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,834	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,834	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,301	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
<b>SWING BED ADJUSTMENT</b>				
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)		2,672,494	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)		2,672,494	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		2,672,494	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,457.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,895,804	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,895,804	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1	
				Component CCN: 14-T046		Date/Time Prepared: 3/28/2018 12:51 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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
<b>Cost Center Description</b>							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						889,015	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,784,819	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						317,145	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						72,123	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						389,268	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,395,551	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	447,071	2,672,494	0.167286	0	0	90.00
91.00	Nursing School cost	0	2,672,494	0.000000	0	0	91.00
92.00	Allied health cost	0	2,672,494	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,672,494	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm
		Title XIX	Hospital	PPS
Cost Center Description				
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,619	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,619	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)		26,316	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)		4,117	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)		1,810	15.00
16.00	Nursery days (title V or XIX only)		1,281	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		32,281,030	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)		32,281,030	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		32,281,030	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,127.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,643,811	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,643,811	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm		
Cost Center Description			Title XIX		Hospital	PPS	
	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)	643,846	1,810	355.72	1,281	455,677	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,434,314	2,874	2,238.80	493	1,103,728	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,203,216	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)					686,058	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					686,058	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,517,158	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)					2,303	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,127.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,597,692	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 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	3,347,270	32,281,030	0.103692	2,597,692	269,360	90.00
91.00	Nursing School cost	0	32,281,030	0.000000	2,597,692	0	91.00
92.00	Allied health cost	0	32,281,030	0.000000	2,597,692	0	92.00
93.00	All other Medical Education	0	32,281,030	0.000000	2,597,692	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,834	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,834	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,834	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)		243	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)		1,810	15.00
16.00	Nursery days (title V or XIX only)		1,281	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		2,672,494	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)		2,672,494	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		2,672,494	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,457.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		354,097	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)		354,097	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
					Component CCN: 14-T046		Date/Time Prepared: 3/28/2018 12:51 pm
					Title XIX	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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
<b>Cost Center Description</b>							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						354,097	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						59,236	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						59,236	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						294,861	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 3/28/2018 12:51 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	447,071	2,672,494	0.167286	0	0	90.00
91.00	Nursing School cost	0	2,672,494	0.000000	0	0	91.00
92.00	Allied health cost	0	2,672,494	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,672,494	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 3/28/2018 12:51 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		17,495,285	30.00
31.00	03100	INTENSIVE CARE UNIT		2,844,000	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.167024	26,559,601	50.00
51.00	05100	RECOVERY ROOM	0.085304	2,616,881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.299990	15,841	52.00
53.00	05300	ANESTHESIOLOGY	0.027582	4,072,245	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241246	4,917,759	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.261936	557	55.00
56.00	05600	RADIOISOTOPE	0.117091	856,781	56.00
57.00	05700	CT SCAN	0.034949	7,252,226	57.00
58.00	05800	MRI	0.070608	610,400	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.073211	7,335,858	59.00
60.00	06000	LABORATORY	0.115258	19,926,111	60.00
64.00	06400	INTRAVENOUS THERAPY	0.246546	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.179315	7,157,144	65.00
66.00	06600	PHYSICAL THERAPY	0.277914	3,481,519	66.00
66.01	06601	CLINICAL NUTRITION	6.093200	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.481874	1,094,949	67.00
68.00	06800	SPEECH PATHOLOGY	0.524698	219,140	68.00
69.00	06900	ELECTROCARDIOLOGY	0.176560	5,036,756	69.00
69.01	06901	CARDIAC REHABILITATION	0.370346	98,840	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.544253	136,307	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.201987	3,909,007	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.348163	7,924,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287719	16,736,305	73.00
74.00	07400	RENAL DIALYSIS	0.400355	1,060,701	74.00
76.00	03950	ACUTE DIALYSIS	0.073540	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.325028	0	90.00
91.00	09100	EMERGENCY	0.230260	4,603,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.156425	151,139	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		125,774,592	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)		125,774,592	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 3/28/2018 12:51 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		1,344,188		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.167024	6,174	1,031	50.00
51.00	05100 RECOVERY ROOM	0.085304	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.299990	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.027582	1,054	29	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.241246	11,541	2,784	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261936	0	0	55.00
56.00	05600 RADIOISOTOPE	0.117091	0	0	56.00
57.00	05700 CT SCAN	0.034949	3,500	122	57.00
58.00	05800 MRI	0.070608	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.073211	0	0	59.00
60.00	06000 LABORATORY	0.115258	91,442	10,539	60.00
64.00	06400 INTRAVENOUS THERAPY	0.246546	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.179315	135,854	24,361	65.00
66.00	06600 PHYSICAL THERAPY	0.277914	879,254	244,357	66.00
66.01	06601 CLINICAL NUTRITION	6.093200	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.481874	862,555	415,643	67.00
68.00	06800 SPEECH PATHOLOGY	0.524698	144,623	75,883	68.00
69.00	06900 ELECTROCARDIOLOGY	0.176560	9,830	1,736	69.00
69.01	06901 CARDIAC REHABILITATION	0.370346	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.544253	1,145	623	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.201987	25,200	30,290	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.348163	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287719	158,635	45,642	73.00
74.00	07400 RENAL DIALYSIS	0.400355	13,300	5,325	74.00
76.00	03950 ACUTE DIALYSIS	0.073540	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1.325028	0	0	90.00
91.00	09100 EMERGENCY	0.230260	133,112	30,650	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.156425	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,477,219	889,015	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,477,219		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		24,425,119	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,703,918	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,434,825	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		117.69	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.95	31.00
32.00	Sum of lines 30 and 31		27.42	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.84	33.00
34.00	Disproportionate share adjustment (see instructions)		951,020	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000148135	0.000146112	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	885,476	988,697	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	662,287	249,206	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	911,493		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
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)	35,426,375		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				<b>1.00</b>
49.00	Total payment for inpatient operating costs (see instructions)		35,426,375	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,888,865	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		5,179	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)		38,320,419	59.00
60.00	Primary payer payments		4,131	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		38,316,288	61.00
62.00	Deductibles billed to program beneficiaries		3,550,520	62.00
63.00	Coinurance billed to program beneficiaries		42,441	63.00
64.00	Allowable bad debts (see instructions)		873,378	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		567,696	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		668,401	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		35,291,023	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)		-126,919	70.93
70.94	HRR adjustment amount (see instructions)		-488,398	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 3/28/2018 12:51 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)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			34,675,706	71.00
71.01	Sequestration adjustment (see instructions)			693,514	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			33,893,382	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)			88,810	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	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
3/28/2018 12:51 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	24,425,119	0	24,425,119		24,425,119	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,703,918	0		7,703,918	7,703,918	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,434,825	0	1,154,896	279,929	1,434,825	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1184	0.1184	0.1184	0.1184		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	951,020	0	722,984	228,036	951,020	11.00
11.01	Uncompensated care payments	36.00	911,493	0	662,287	249,206	911,493	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	35,426,375	0	26,965,286	8,461,089	35,426,375	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	35,426,375	0	26,965,286	8,461,089	35,426,375	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,888,865	0	2,210,827	678,038	2,888,865	16.00
17.00	Special add-on payments for new technologies	54.00	5,179	0	5,179	0	5,179	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	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
3/28/2018 12:51 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	29,181,292	9,139,127	38,320,419	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,584,688	0	1,962,110	622,578	2,584,688	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	304,177	0	248,717	55,460	304,177	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,888,865	0	2,210,827	678,038	2,888,865	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.250000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				2,284,782	2,284,782	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/28/2018 12:51 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	24,425,119	24,425,119		24,425,119	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,703,918		7,703,918	7,703,918	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,434,825	1,154,896	279,929	1,434,825	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	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
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	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1184	0.1184	0.1184		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	951,020	722,984	228,036	951,020	11.00
11.01	Uncompensated care payments	36.00	911,493	662,287	249,206	911,493	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	35,426,375	26,965,286	8,461,089	35,426,375	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	35,426,375	26,965,286	8,461,089	35,426,375	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,888,865	2,210,827	678,038	2,888,865	16.00
17.00	Special add-on payments for new technologies	54.00	5,179	5,179	0	5,179	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			29,181,292	9,139,127	38,320,419	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0046

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

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
3/28/2018 12:51 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	2,584,688	1,962,110	622,578	2,584,688	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	304,177	248,717	55,460	304,177	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	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	2,888,865	2,210,827	678,038	2,888,865	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	-126,919	-119,671	-7,248	-126,919	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	-488,398	-342,024	-146,374	-488,398	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		79,226	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,642,160	2.00
3.00	OPPS payments		15,781,713	3.00
4.00	Outlier payment (see instructions)		216,413	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)		79,226	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		275,767	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)		275,767	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		275,767	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		196,541	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 (line 11 minus line 20) (see instructions)		79,226	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)		15,998,126	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,121,815	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)		12,955,537	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,955,537	30.00
31.00	Primary payer payments		368	31.00
32.00	Subtotal (line 30 minus line 31)		12,955,169	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		440,267	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		286,174	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		261,980	36.00
37.00	Subtotal (see instructions)		13,241,343	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-42	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)		13,241,385	40.00
40.01	Sequestration adjustment (see instructions)		264,828	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		12,884,582	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		91,975	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 14-0046		Period: From 01/01/2017 To 12/31/2017		Worksheet E-1 Part I Date/Time Prepared: 3/28/2018 12:51 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		33,680,759		12,679,241	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		173,071		166,826	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	06/08/2017	39,552	06/08/2017	38,515	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)		39,552		38,515	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)		33,893,382		12,884,582	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		88,810		91,975	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		33,982,192		12,976,557	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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Prepared: 3/28/2018 12:51 pm	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0
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		2,333,826		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/08/2017	12,901		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		12,901		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,346,727		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		8,492		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,355,219		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		7,544	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		16,771	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		1,677	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		29,190	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		546,290,606	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		11,577,740	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			2,233,339 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0173 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			97,820 3.00
4.00	Outlier Payments			88,035 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			5.024658 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,419,194 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,419,194 17.00
18.00	Primary payer payments			1,581 18.00
19.00	Subtotal (line 17 less line 18).			2,417,613 19.00
20.00	Deductibles			7,896 20.00
21.00	Subtotal (line 19 minus line 20)			2,409,717 21.00
22.00	Coinsurance			9,212 22.00
23.00	Subtotal (line 21 minus line 22)			2,400,505 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,277 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,780 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,277 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,403,285 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,403,285 32.00
32.01	Sequestration adjustment (see instructions)			48,066 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,346,727 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			8,492 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			88,035 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0046

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

Worksheet G

Date/Time Prepared:  
3/28/2018 12:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	23,774,091	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	22,074,726	0	0	0	4.00
5.00	Other receivable	3,108,370	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,292,377	0	0	0	7.00
8.00	Prepaid expenses	2,440,612	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)	55,690,176	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	632,759	0	0	0	12.00
13.00	Land improvements	6,642,350	0	0	0	13.00
14.00	Accumulated depreciation	-4,008,871	0	0	0	14.00
15.00	Buildings	171,991,241	0	0	0	15.00
16.00	Accumulated depreciation	-34,862,093	0	0	0	16.00
17.00	Leasehold improvements	17,438,653	0	0	0	17.00
18.00	Accumulated depreciation	-4,382,770	0	0	0	18.00
19.00	Fixed equipment	15,130,530	0	0	0	19.00
20.00	Accumulated depreciation	-5,224,922	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	47,342,677	0	0	0	23.00
24.00	Accumulated depreciation	-35,108,617	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	175,590,937	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	4,437,290	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	18,034,269	430,992	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,471,559	430,992	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	253,752,672	430,992	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	9,033,117	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,749,517	0	0	0	38.00
39.00	Payroll taxes payable	173,198	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,841,642	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,569,969	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,367,443	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	165,978,035	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	877,316	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	166,855,351	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	186,222,794	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	67,529,878				52.00
53.00	Specific purpose fund		430,992			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)	67,529,878	430,992	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	253,752,672	430,992	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0046

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

Worksheet G-1

Date/Time Prepared:  
3/28/2018 12:51 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		75,572,032		444,746		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		7,945,846				2.00
3.00	Total (sum of line 1 and line 2)		83,517,878		444,746		3.00
4.00	Additions ADJUSTMENTS	277,287		79,402		0	4.00
5.00	CORPORATE OFFICE	487,813		0		0	5.00
6.00	GAIN ON INVESTMENTS	0		0		0	6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA	0		0		0	7.00
8.00	TRANSFERS FROM OTHER FUNDS	0		0		0	8.00
9.00	DONATIONS	0		7,550		0	9.00
10.00	Total additions (sum of line 4-9)		765,100		86,952		10.00
11.00	Subtotal (line 3 plus line 10)		84,282,978		531,698		11.00
12.00	Deductions ADJUSTMENTS	9,052,924		100,706		0	12.00
13.00	CORPORATE OFFICE	0		0		0	13.00
14.00	LOSS ON INVESTMENTS	0		0		0	14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZATI	7,700,176		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		16,753,100		100,706		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		67,529,878		430,992		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions ADJUSTMENTS		0				4.00
5.00	CORPORATE OFFICE		0				5.00
6.00	GAIN ON INVESTMENTS		0				6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA		0				7.00
8.00	TRANSFERS FROM OTHER FUNDS		0				8.00
9.00	DONATIONS		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 ADJUSTMENTS		0				12.00
13.00	CORPORATE OFFICE		0				13.00
14.00	LOSS ON INVESTMENTS		0				14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZATI		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: 14-0046

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
3/28/2018 12:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	33,928,960		33,928,960	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,943,432		1,943,432	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)	35,872,392		35,872,392	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,280,455		6,280,455	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)	6,280,455		6,280,455	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,152,847		42,152,847	17.00
18.00	Ancillary services	230,994,007	247,841,970	478,835,977	18.00
19.00	Outpatient services	7,675,834	31,932,673	39,608,507	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE PROFESSIONAL FEES	16,105,832	9,568,828	25,674,660	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	296,928,520	289,343,471	586,271,991	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		187,553,678		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)		187,553,678		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 3/28/2018 12: 51 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	586,271,991	1.00
2.00	Less contractual allowances and discounts on patients' accounts	399,690,674	2.00
3.00	Net patient revenues (line 1 minus line 2)	186,581,317	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	187,553,678	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-972,361	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	227,141	6.00
7.00	Income from investments	299,524	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	4,188	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	811,661	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	7,957	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	89,471	20.00
21.00	Rental of vending machines	11,148	21.00
22.00	Rental of hospital space	496,792	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	6,970,325	24.00
25.00	Total other income (sum of lines 6-24)	8,918,207	25.00
26.00	Total (line 5 plus line 25)	7,945,846	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,945,846	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0046	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 3/28/2018 12:51 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,584,688	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		304,177	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)		82.60	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		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)		2,888,865	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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